

**ORIGINAL**

**TRISTAR HORIZON  
MEDICAL CENTER NICU**

**CN1510-047**

007 15 15 15 15

October 15, 2015

Melanie Hill, Executive Director  
Tennessee Health Services and Development Agency  
Andrew Jackson Building, 9<sup>th</sup> Floor  
502 Deaderick Street  
Nashville, TN 37243


RE: CON Application Submittal  
TriStar Horizon Medical Center NICU  
Dickson, Dickson County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

  
John Wellborn  
Consultant

00715 15 3-8

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

John L Wellborn  
SIGNATURE/TITLE  
CONSULTANT

Sworn to and subscribed before me this 15<sup>th</sup> day of October, 2015 a Notary  
(Month) (Year)

Public in and for the County/State of DAVIDSON



Jan M. Danforth  
NOTARY PUBLIC

My commission expires July 2, 2015  
(Month/Day) (Year)

Continued from last column

the FTP site can be obtained by contacting the Project Manager (E-mail is preferred). Proposals will be accepted until 2:00 PM EST on the proposal date shown above.

**Real Estate****Rentals**

great places to live...

**Com/Industrial Lease**

**ASHLAND CITY**, Approx. 1000 sq.ft. office space. Downtown across from County Offices. Newly renovated. Perfect for lawyer or any professional occupation. \$795 mo. 615-792-3029

**BELLEVUE** Beauty/Spa 10x12 Rooms, three avail. Furnished, ready for you to set up your business, \$150 week includes utilities. Call 615-662-1220

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**BELLEVUE**, spacious 3 bdrm, 2 BA condo for lease on quiet cul-de-sac. FP, DR. \$1325, mo. 615-673-1279

**Green Hills** \$1,400, 2 bdrm, 1.5 ba, Heat & water incl., w/d, porch, pool, refs req'd. Close to mall, universities, & ent. (615)243-9702 Jahbless53@hotmail.com

**Public Notices**

0000785421

**NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED**

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Horizon Medical Center (a hospital), owned and managed by Central Tennessee Hospital Corporation, Inc. (a corporation), intends to file an application for a Certificate of Need to initiate neonatal intensive care nursery services in a 6-bed Level II neonatal nursery, by renovation of existing space on its main campus at 111 Highway 70 East in Dickson, TN 37055, at a capital cost estimated at \$975,500.

TriStar Horizon Medical Center is licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, as a 157-bed general hospital. The project does not change the hospital's licensed bed count, and does not contain major medical equipment or initiate or discontinue any other health service.

The anticipated date of filing the application is on or before October 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215, (615) 665-2022. Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency  
Andrew Jackson Building, 9th Floor  
502 Deaderick Street  
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

**Homes For Rent**

**1-5 BR Avail. All Prices Sizes & Areas.**  
Bad CR, Sec 8 OK. 100's avail NOW!  
888-471-RENT [HometownRentals.info](http://HometownRentals.info)

**BELLEVUE** 3 Bdrm, bonus rm, 2.5 BA, den, fireplace, living/dining, utility room with W/D, all appliances, covered patio, pets neg. \$1800 mo. 615-476-5178

**EAST/SOUTH NASHVILLE**  
(3 Houses avail) 2 Bdrm, \$500-\$700 mo. \$300 dep. Slave, fridge furnished, carpeted. (In Triplex), 1 Bdrm, \$450 mo. \$300 dep. No pets. 615-424-6837

**FRANKLIN (DOWNTOWN)**, 3 Bdrm, 1 BA house for lease, central H/A, no appls or utils furnished, w/d hook-ups, no smoking, no pets, ref's req'd, \$1200 mo. \$1200 dep. Call 615-604-9791

**Duplexes**

**MADISON/RIVERGATE** 2 bdrm, private homes area, dep., 100sq, credit/background check, no pets, drugs, hookups, \$710 neg., 615-758-8178

**Apt Furnished**

**AIRPORT Area**, 981 Murfreesboro Pk. Furnished efficiency w/TV. \$695 mo. All utilities paid. Cable TV + HBO. Call 615-750-2159

**MADISON Rivergate** - Furnished & unfurnished, wkly/mo, 1 Bdrms, Util, Appl. Call 573-7377 943-6071

**NORTH Large & small furnished efficiency, utilities included,**  
2126 15th Ave. North,  
\$120 & up per week. Call 978-235-6063.

**Public Notices****Apt Furnished**

**OLD HICKORY** ★ Furnished Apt. Recently Remodeled 1 Bdrm. 1 BA in quiet area. Includes utilities \$165/wk. Cell 615-838-6252

**OLD HICKORY OR DONELSON** - Male wanted to share a nice 4 Bdrm, fully furnished, sober living House at either location. Incl cable TV & W/D, utils incl. \$135/wk + dep. 615-202-8671

**STADIUM INN Weekly Rates**  
\$225 & Up. Also Monthly Rates.  
Front Desk Person Needed.  
★ 615-244-6052 ★★ 244-6053 ★

**Apt Unf-Davidson North**

**HAMPTON TERRACE**  
1-BR from \$479 2-BR from \$579  
Pets-Water-Appliances-Cable.  
No Security deposit In Madison. 865-5360

★ ★ **MADISON** ★ ★  
**1 BR APTS AVAIL. FALL Specials!!**  
Call for Details...481-9788

**Public Notices**

0000786905

**NOTICE TO CONSULTANT ENGINEERS REGARDING A REQUEST FOR QUALIFICATIONS AND LETTERS OF INTEREST OF INTEREST OCTOBER 5, 2015**

The City of Berry Hill, Tennessee, an Equal Opportunity, Affirmative Action Employer, seeks to retain the services of a professional consultant engineering firm to provide services related to the Franklin Pike Multi-modal Plan (PIN 121988.00), funded in part by federal funds provided through the Tennessee Department of Transportation. The project shall be accomplished in accordance with the project plans and the requirements of TDOT's Local Programs Development Office. The professional engineering consulting firm must be on TDOT's pre-approved list and must have unlimited status. Responsibilities of the professional engineering firm include, but are not limited to: (a) field surveying (b) engineering (c) multi-modal corridor planning. Method of payment will be check issued from verified invoice. For a more detailed scope of work, contact Joe Baker, City Manager, (615) 292-5531, email: [jbaker@berryhilltn.net](mailto:jbaker@berryhilltn.net).

Firms may request consideration by submitting three copies of a letter of interest along with qualifications to Joe Baker, City Manager, at 698 Thompson Lane, Nashville, Tennessee 37204. All letters of interest and qualifications must be received by the City on or before 4:00 p.m. CDT, October 30, 2015. The letter of interest and qualifications shall indicate the scope of services to be completed by any subconsultants. Response packages shall not exceed ten (10) pages in length.

Prequalification procedures, example letter of interest, list of pre-qualified firms and certified DBEs, TDOT's standard procurement policy, and additional information can be found at the following web site address: [www.tn.gov/dot/topic/consultantinfo](http://www.tn.gov/dot/topic/consultantinfo).

The City will evaluate the qualifications for those submitting responses and will select one firm with which to attempt negotiations for a contract in accordance with TDOT's procurement procedures. The factors that will be considered in evaluation of proposals are:

- Past experience specific to TDOT Local Programs projects.
- Past experience with similar projects.
- Knowledge of the corridor and experience within the City of Berry Hill.
- Qualifications and availability of staff.
- Demonstrated ability to meet schedules without compromising sound engineering practice.
- Evaluations on prior projects with TDOT and other clients, if available.
- Amount of work under contract with TDOT and other clients.
- Knowledge of Federal and TDOT CEI requirements.

Evaluation proceedings will be conducted within the established guidelines regarding equal employment opportunity and nondiscriminatory action based upon the grounds of race, color, sex, creed or national origin. Interested certified Disadvantaged Business Enterprise (DBE) firms as well as other minority-owned and women-owned firms are encouraged to respond to all advertisements by the City of Berry Hill.

**Apt Unf-Davidson SE**

**AIRPORT AREA**, 985 Murfreesboro Pike. Unfurnished Efficiency, \$550 mo. All utilities paid. Call 615-750-2159

**Apt Unf-Davidson West**

**Antioch - STAY LODGE**  
**Best Deal In Town !!**  
Efficiency Studio With Kitchen, Laundry, Cable, & Utilities. Free Local Calls. \$172.99+tax/wk & \$50 Security Deposit. 615-333-6700

**RENT SPECIAL**

**GREEN HILLS**, \$1195, mo. 2bdrm, 1BA 2 min to Whole Foods/Green Hills Mall, Woodmont Ln. Ref. No pets. 615-495-1553

**Public Notices****Call 615-242-SALE****Davidson Southwest****ESTATE SALE**

**BELLEVUE SALE**  
Oct 8-10, 9am - 4pm

508 General George Patton, 37221  
Victorian, QA Bonnet Highboy, Pine Chest, Oil Paintings, Sofa, Club Chairs, Staffordshire/Lladro Figurines, Silverplate, Heywood Wakefield Coffee Table, Mirrors, Copper Samovar, Vintage Books, 3 Set Walnut Bedroom, Q Metal Bed, Flow

**Davidson West**

**NASHVILLE, MULTI-FAMILY YARD SALE**, 57 VAUGHNS GAP RD, SATURDAY ONLY 10/10/2015, 7AM TO 4PM. Dir: HIGHWAY 70 WEST TO VAUGHNS GAP -TURN LEFT ONTO VAUGHNS GAP. TOYS, GAMES, SPORTS CLOTHING, BOOKS, HOME DECOR, FRAMED ART & MUCH MORE! THIS IS FINAL DAY -ALL MUST GO!

**Maury County****Williamson County**

**Brentwood, Moving Sale** Chestnut Springs Sub. 9729 Northfork Dr., Oct. 10 & 11, Sat. 7am-3pm Sun 1-4pm.

**Fairview 7106 PLEASANT GROVE CT**  
**McCORMICK GROVE SUBDIV.**  
Sat., Oct. 10, 8am-2pm

**FRANKLIN**, Fri, Sat, Oct 9, 10. 3228 Gardendale Dr. Furniture, antiques, household items, book shelves, lots of

**TRISTAR HORIZON  
MEDICAL CENTER**

**CERTIFICATE OF NEED APPLICATION  
TO ESTABLISH A SIX-BED  
NEONATAL INTENSIVE CARE UNIT (NICU)  
IN DICKSON COUNTY**

**Submitted October 2015**

## ***PART A***

### ***1. Name of Facility, Agency, or Institution***

TriStar Horizon Medical Center Neonatal Intensive Care Unit (NICU)		
<i>Name</i>		
111 Highway 70 East		Dickson
<i>Street or Route</i>		<i>County</i>
Dickson	TN	37055
<i>City</i>	<i>State</i>	<i>Zip Code</i>

### ***2. Contact Person Available for Responses to Questions***

John Wellborn		Consultant	
<i>Name</i>		<i>Title</i>	
Development Support Group		jwdsg@comcast.net	
<i>Company Name</i>		<i>E-Mail Address</i>	
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
<i>Street or Route</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
CON Consultant	615-665-2022	615-665-2042	
<i>Association With Owner</i>	<i>Phone Number</i>	<i>Fax Number</i>	

### ***3. Owner of the Facility, Agency, or Institution***

Central Tennessee Hospital Corporation, Inc.	615-326-2357
<i>Name</i>	<i>Phone Number</i>
Same as in #1 above	Dickson
<i>Street or Route</i>	<i>County</i>
Dickson	TN 37055
<i>City</i>	<i>State Zip Code</i>

### ***4. Type of Ownership or Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For-Profit)	x	I. Other (Specify):	
E. Corporation (Not-for-Profit)			

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND  
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS**

**5. *Name of Management/Operating Entity (If Applicable)***      **NA**

<i>Name</i>		
<i>Street or Route</i>	<i>County</i>	
<i>City</i>	<i>State</i>	<i>Zip Code</i>

**6. *Legal Interest in the Site of the Institution (Check One)***

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of      Years			

**7. *Type of Institution (Check as appropriate—more than one may apply)***

A. Hospital (Specify): General	x	I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Facility		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

**8. *Purpose of Review (Check as appropriate—more than one may apply)***

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, <u>Designation</u> , Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)    NICU	x		
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

### 9. Bed Complement Data

*(Please indicate current and proposed distribution and certification of facility beds.)*

	<b>Current Licensed Beds</b>	<b>CON approved beds (not in service)</b>	<b>Staffed Beds</b>	<b>Beds Proposed (Change)</b>	<b>TOTAL Beds at Completion</b>
A. Medical	123		72	-6	117
B. Surgical (In A)					
C. Long Term Care Hosp.					
D. Obstetrical	9		9		9
E. ICU/CCU	6		6		6
F. Neonatal	0			+6	6
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric	7		0		7
J. Child/Adolesc. Psych.					
K. Rehabilitation	12		12		12
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
<b>TOTAL</b>	<b>157</b>		<b>99</b>	<b>0</b>	<b>157</b>

<b>10. Medicare Provider Number:</b>	440046
<b>Certification Type:</b>	General Hospital
<b>11. Medicaid Provider Number:</b>	44-0046
<b>Certification Type:</b>	General Hospital

**12. & 13. See page 4**

**A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?**

This is an existing hospital that is certified for both Medicare and TennCare/Medicaid.

**A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.**

**DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.**

<b>Table One: Contractual Relationships with Service Area MCO's</b>	
<b>Available TennCare MCO's</b>	<b>Applicant's Relationship</b>
AmeriGroup	contracted
United Healthcare Community Plan	contracted
BlueCare	contracted
TennCare Select	contracted

## **SECTION B: PROJECT DESCRIPTION**

**B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.**

### Proposed Services and Equipment

- TriStar Horizon Medical Center is in Dickson, near I-40 in western Middle Tennessee. It serves a large rural area between Nashville and the Tennessee River, whose residents have many births requiring Level II neonatal intensive care. This project is to establish a Level II Neonatal Intensive Care Unit ("NICU") with 6 licensed beds. It will be staffed 24/7 by neonatal nurse practitioners working under the supervision of neonatologists on staff at TriStar Centennial Medical Center, the second largest Level III neonatal care program in Middle Tennessee. This neonatology group belongs to the Pediatrix organization, which manages neonatal care at seven Middle Tennessee NICU's.
- No new construction is needed. The NICU will be developed in existing space. No major medical equipment is required. There will be no increase in the hospital's bed license, because 6 underutilized medical-surgical beds will be closed when the NICU opens.

### Ownership Structure

- TriStar Horizon Medical Center is wholly owned by Central Tennessee Hospital Corporation, which is owned through subsidiary companies by HCA, the nation's largest hospital corporation. HCA operates three NICU's in Tennessee and operates one of the two neonatal ambulance transport systems that serve the Middle Tennessee Region.
- Attachment A.4 contains more details, an organization chart, and information on the Tennessee facilities owned by this facility's parent organization.

### Service Area

- The primary service area of the project will consist of all or part of four contiguous counties-- Dickson, Houston, Humphreys, and the northernmost zip code of Hickman County (37025), which is close to Dickson.
- This is a rural area one to two hours' drive west of Nashville and east of the Tennessee River. The service area extends both north and south of I-40 as it crosses West Tennessee. It can be described as central western Middle Tennessee.

## Need

- In early CY 2015, the perinatal community redefined Level II care to include certain infants with persistent low blood sugar problems, who traditionally had been cared for in Level I facilities. IN CY 2015, this change has caused the applicant's Level I program to have to transport 160% more inborns (born at this hospital) to Level II NICU's outside the service area. Such extreme separation of the mothers from their babies for an average of two weeks is not desirable from the standpoint of family bonding, breastfeeding, and other goals. Not having a Level II resource close to home imposes a severe daily travel burden on local families and necessitates much larger neonatal transport costs. Recent trends suggest that one in three area newborns are being transferred to Level II NICU's. If this continues, mothers will increasingly choose to deliver in Nashville. This will increasingly threaten the viability of the Horizon obstetrics program, creating a significant gap in accessibility and safety for service area residents who rely on Horizon.
- With its strong relationships to the Level III NICU at TriStar Centennial Women's and Children's Hospital in Nashville (where most of these new transfers have gone), the applicant can quickly upgrade its staffing and staff competencies to meet the current Perinatal Guidelines for Level II care. Having the Level II competencies and designation will greatly reduce the commuting burdens on families who currently must make long round trips outside the area daily--for almost two weeks on average--to be with their newborns in Level II care. It will reduce the costs of neonatal transport. It will help retain and expand this hospital's maternity programs, keeping them from declining to the point that the rural service area cannot retain its obstetricians.

## Existing Resources

- There are no Level II NICU services available in the primary service area, which consists of all or parts of four counties that generate almost a thousand births a year. The applicant's Level I neonatal nursery is the only one in the service area.
- East of the project service area, the closest NICU's are at TriStar Centennial Medical Center (The Children's Hospital at Centennial Medical Center), Vanderbilt Medical Center (Vanderbilt Children's Hospital), and Saint Thomas Midtown Hospital (formerly Baptist Hospital). To the north and south of the service area there are NICU's at Gateway Medical Center in Clarksville, and Maury Regional Medical Center in Columbia. These are all a long drive from this project's service area.

## Project Cost and Funding, and Financial Feasibility

- The estimated cost of the project is \$975,500. The project cost will be fully funded with the cash reserves of the applicant hospital. The project will operate with a positive cash flow and a positive operating margin. The hospital of which it is a part currently has a positive cash flow.

## Staffing

- The NICU will be staffed in compliance with the standards of the Tennessee Perinatal Care System Guidelines. The current edition of those is the Seventh Edition (April 24, 2014). This will require the addition of approximately 12.4 FTE's.

**B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.**

**B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.*) INCLUDING SQUARE FOOTAGE, MAJOR OPERATIONAL AREAS, ROOM CONFIGURATION, ETC.**

Location

The project will be located on the second floor of TriStar Horizon Medical Center in Dickson, the county seat of Dickson County. The hospital is located approximately 5.5 miles north of I-40's Highway 46 exit.

Design

<b>Table One-A: Summary of Construction and Changes in Size</b>	
	<b>Total Square Feet</b>
Net Increase in Facility Size (%)	None
Area of New Construction	None
Area of Renovation	1,500 SF

<b>Table One-B: Construction Costs of This Project</b>			
	<b>Renovated Construction</b>	<b>New Construction</b>	<b>Total Project</b>
Square Feet	1,500 SF	0	1,500 SF
Construction Cost	\$374,500	0	\$374,500
Constr. Cost PSF	\$250 PSF	0	\$250 PSF

The proposed NICU will be constructed by renovating and remodeling existing space in the hospital's second floor nursery, adjacent to Obstetrics. A Neonatal Intensive Care Unit ("NICU") of six (6) licensed bassinets will be created there, staffed and equipped for the delivery of Level II care as defined by current Guidelines of the Tennessee Perinatal Care System (Seventh Edition, 2014). A preliminary floor plan for the NICU is provided below, at the end of this response to B.II.A. The equipment cost is estimated at \$500,000.

### Scope of Service

The NICU will care for infants of 32 or more weeks' gestational age, with birth-weights at or above 1500 grams, who have physiologic immaturity or are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. It will be capable of stabilizing infants of less than 32 weeks gestational age, or less than 1,500 grams birth-weight, for safe transfer to a higher level of NICU care in Nashville. The unit will provide mechanical ventilator support of less than 24 hours or continuous positive airway pressure or both. It will provide care for infants who are convalescing after more intensive care at other locations.

### Operational Schedule

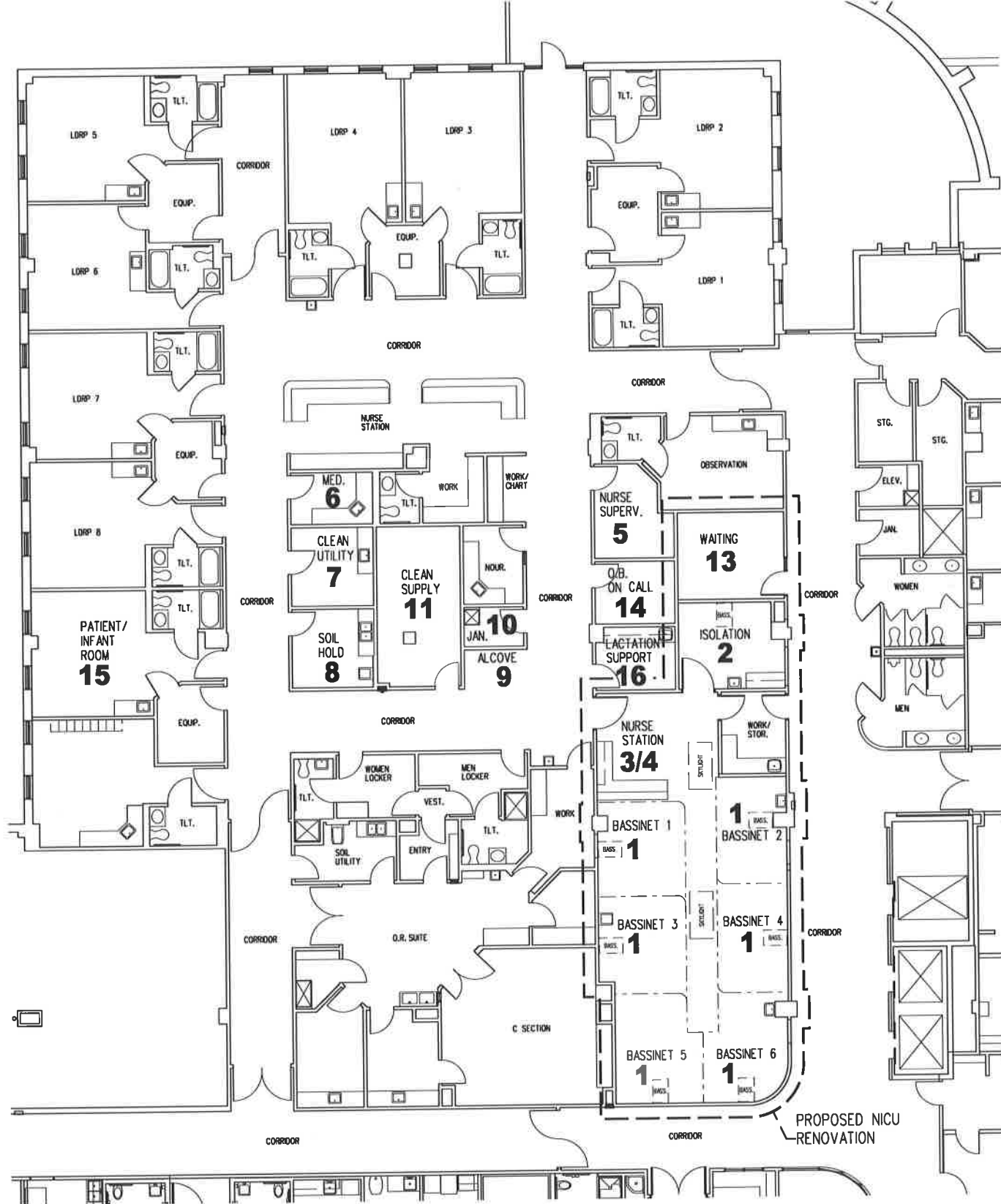
If granted CON approval in early 2016, the project can be completed and opened no later than January 1, 2017. It will be operated 24 hours daily, 7 days a week, as an inpatient acute care Level II nursery.

### Project Cost and Financing

The estimated project cost for CON purposes is \$975,500. This will be entirely funded by the hospital's parent company, HCA, Inc., by means of a cash transfer to TriStar Health System, the local HCA Division office of which TriStar Horizon is a part.

### Ownership of the Applicant

Horizon Medical Center's owner is Central Tennessee Hospital Corporation, a wholly-owned subsidiary of HCA, Inc., whose Tennessee ownership interests are set forth in materials in the Attachments.



#### REQUIRED SPACES:

1. INFANT CUBICLE
2. AIRBORNE INFECTION ISOL. RM.
3. NURSE STATION
4. CHART AREA
5. NURSE SUPV. OFFICE
6. MED. STATION
7. CLEAN WORK
8. SOIL HOLD

9. EMERGENCY EQUIP. STG.
10. ENVIRONMENTAL SERVICE RM.
11. EQUIPMENT STORAGE
12. STAFF LOCKER/TLT
13. VISITOR WAITING
14. PHYSICIAN SLEEP
15. PATIENT/INFANT ROOM
16. LACTATION SUPPORT

Nursery Intensive Care Unit  
**TriStar Horizon**  
**MEDICAL CENTER**  
 Dickson, Tennessee

**APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF \$5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF \$2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART.**

**UTILIZING THE ATTACHED CHART, APPLICANTS WITH HOSPITAL PROJECTS SHOULD COMPLETE PARTS A-E BY IDENTIFYING, AS APPLICABLE, NURSING UNITS, ANCILLARY AREAS, AND SUPPORT AREAS AFFECTED BY THIS PROJECT. PROVIDE THE LOCATION OF THE UNIT/SERVICE WITHIN THE EXISTING FACILITY ALONG WITH CURRENT SQUARE FOOTAGE, WHERE, IF ANY, THE UNIT/SERVICE WILL RELOCATE TEMPORARILY DURING CONSTRUCTION AND RENOVATION, AND THEN THE LOCATION OF THE UNIT/SERVICE WITH PROPOSED SQUARE FOOTAGE. THE TOTAL COST PER SQUARE FOOT SHOULD PROVIDE A BREAKOUT BETWEEN NEW CONSTRUCTION AND RENOVATION COST PER SQUARE FOOT. OTHER FACILITY PROJECTS NEED ONLY COMPLETE PARTS B-E.**

Not applicable. The construction involved is much lower than this threshold.

**PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.**

Hospital construction projects approved by the HSDA in 2012-2014 had the following construction costs per SF:

<b>Table Two: Hospital Construction Cost PSF Years 2012-2014</b>			
	Renovated Construction	New Construction	Total Construction
1 <sup>st</sup> Quartile	\$110.98/sq ft	\$224.09/sq ft	\$156.78/sq ft
Median	\$192.46/sq ft	\$259.66/sq ft	\$227.88/sq ft
3 <sup>rd</sup> Quartile	\$297.82/sq ft	\$296.52/sq ft	\$298.66/sq ft

*Source: HSDA Registry; CON approved applications for years 2012-2014.*

This project is renovation only; estimated cost will be \$250 PSF. This is below the third quartile average costs for hospital renovation projects, as compiled by the HSDA Registry.

**IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.**

Not applicable.

**IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.**

Not applicable.

**B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.**

<b>Table Three: Proposed Changes in Assignment of Licensed Hospital Beds at TriStar Horizon Medical Center</b>		
<b>Bed Assignment</b>	<b>Current Assignment</b>	<b>Proposed Assignment (Change)</b>
General Medical-Surgical	123	117 (-6)
Critical Care	6	6
NICU	0	+6
Obstetrics	9	9
Psychiatric	7	7
Rehabilitation	12	12
Total Licensed Complement	157	157

The hospital has excess medical-surgical beds that can be de-licensed to offset the licensure of the proposed six NICU bassinets. At this time it would not adversely impact the ability of the hospital to meet area demand for medical-surgical inpatient beds.

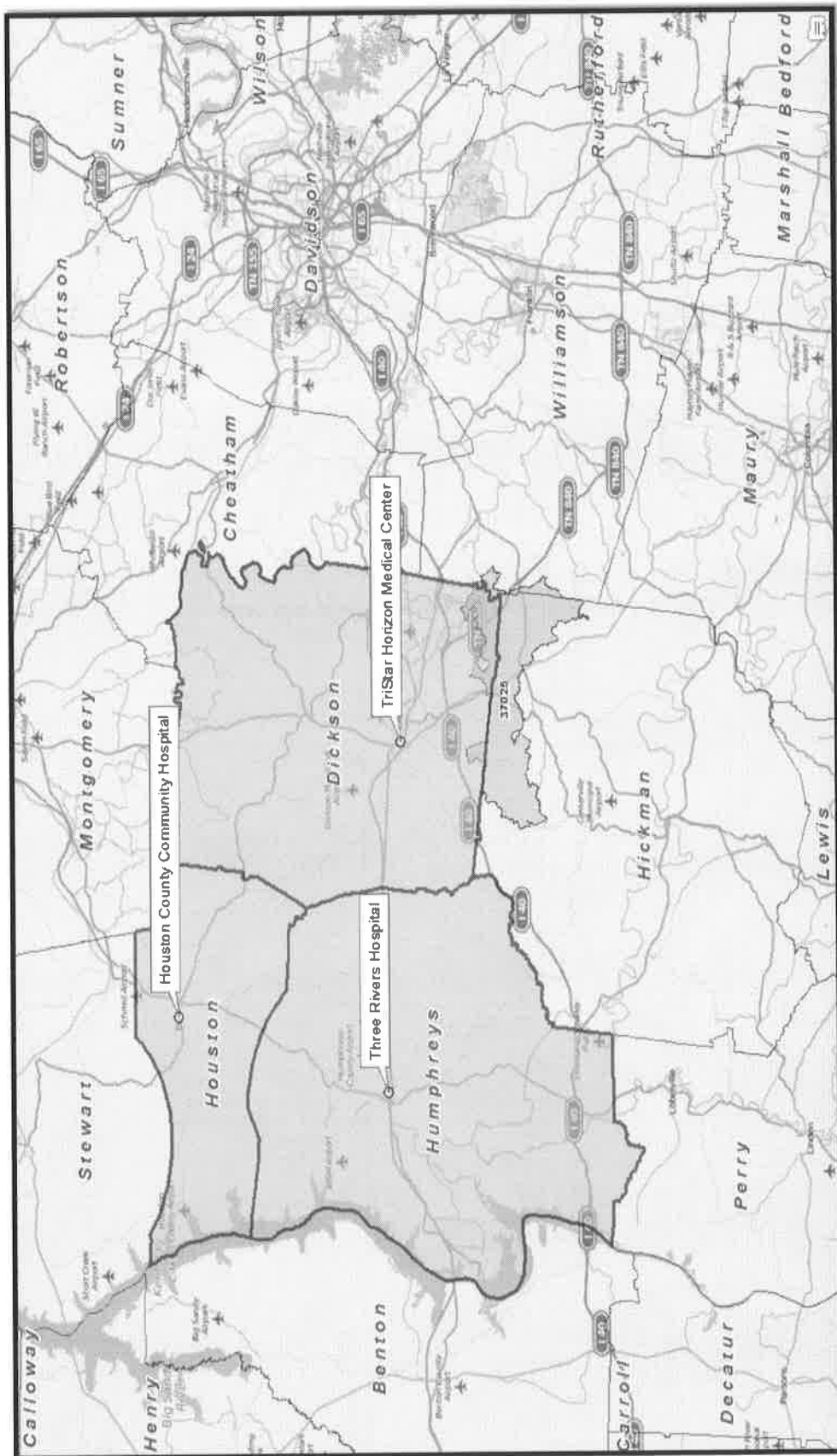
**B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):**

- 1. ADULT PSYCHIATRIC SERVICES**
- 2. ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
- 3. BIRTHING CENTER**
- 4. BURN UNITS**
- 5. CARDIAC CATHETERIZATION SERVICES**
- 6. CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
- 7. EXTRACORPOREAL LITHOTRIPSY**
- 8. HOME HEALTH SERVICES**
- 9. HOSPICE SERVICES**
- 10. RESIDENTIAL HOSPICE**
- 11. ICF/MR SERVICES**
- 12. LONG TERM CARE SERVICES**
- 13. MAGNETIC RESONANCE IMAGING (MRI)**
- 14. MENTAL HEALTH RESIDENTIAL TREATMENT**
- 15. NEONATAL INTENSIVE CARE UNIT**
- 16. NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
- 17. OPEN HEART SURGERY**
- 18. POSITIVE EMISSION TOMOGRAPHY**
- 19. RADIATION THERAPY/LINEAR ACCELERATOR**
- 20. REHABILITATION SERVICES**
- 21. SWING BEDS**

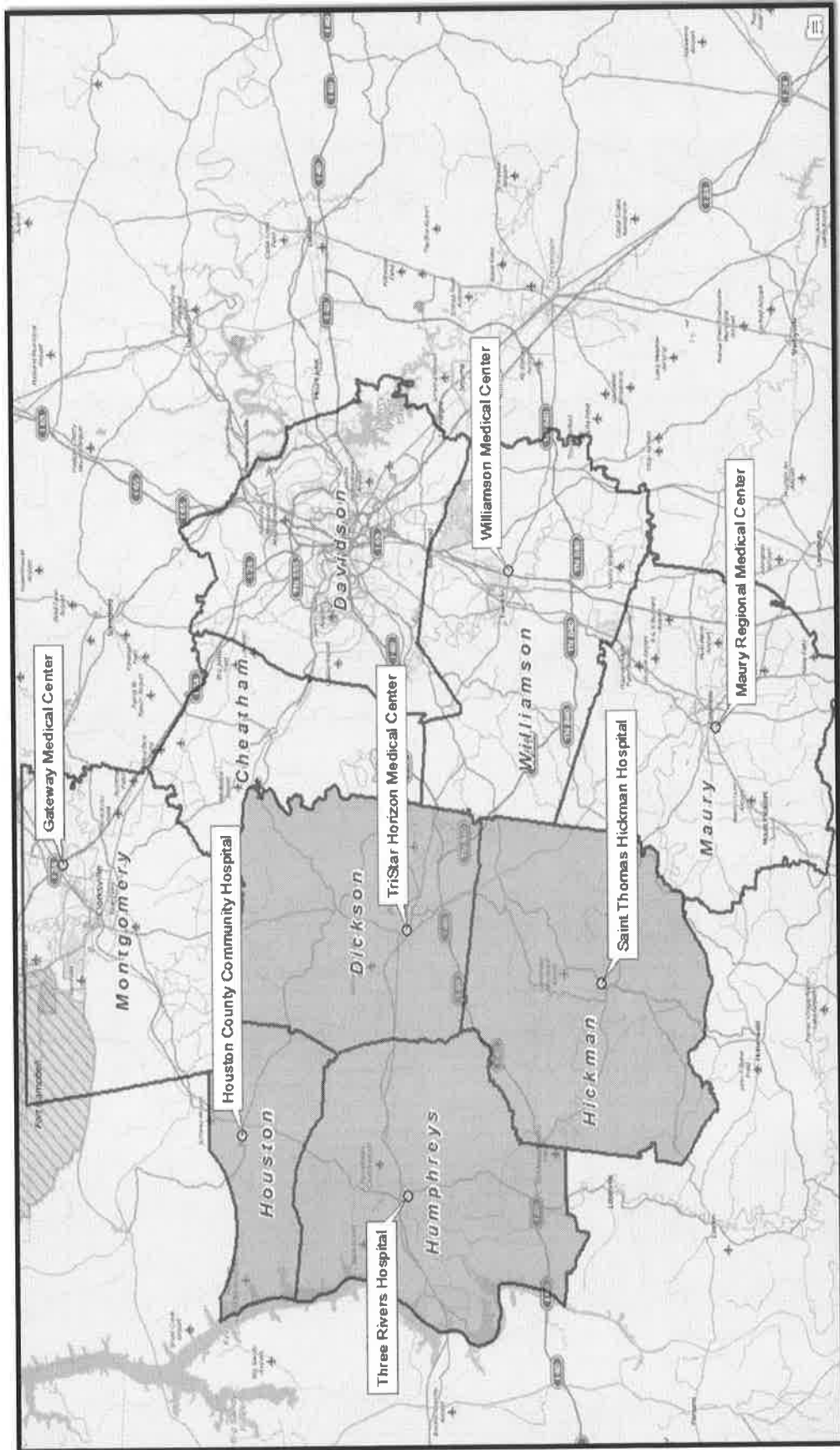
The Project's Primary Service Area

The primary service area of this project consists of three adjacent counties, and part of a fourth, in western Middle Tennessee: Dickson, Houston, Humphreys, and zip code 37025 in northern Hickman County. These four counties are situated midway between Nashville and the Tennessee River, on both the north and south sides of I-40, the principal east-west highway across the region. This is a rural service area, in which the largest and fastest-growing county is Dickson County.

Two maps are provided on the following pages. The first map is the project's primary service area, showing the three counties and the northern zip code of the fourth (Hickman). The second map is a larger scale map showing hospitals within the service area counties, and the closest three NICU's outside the service area, in Clarksville, Columbia, and Franklin.



PROJECT SERVICE AREA



COUNTIES UTILIZING THE PROJECT  
(NORTHERN HICKMAN COUNTY ONLY)

## Perinatal Resources and Activities in the Primary Service Area

As shown in Table Four-A below, the four counties included wholly or partially in the project service area contain only one obstetrics and nursery care provider--TriStar Horizon Medical Center in Dickson (Dickson County). There are three other acute care hospitals in those counties--Houston County Community Hospital in Erin (Houston County); Three Rivers Hospital in Waverly (Humphreys County); and Saint Thomas Hickman County Hospital in Centerville. All are 25-bed Critical Access Hospitals. The Erin and Waverly hospitals have both expressed strong support for this application.

<b>Table Four-A: Obstetrics and Nursery Services in Service Area Counties</b>					
<b>County</b>	<b>City</b>	<b>Hospital</b>	<b>Beds</b>	<b>OB</b>	<b>Nursery</b>
Dickson	Dickson	TriStar Horizon Medical Center	157	yes	Level I
Humphreys	Waverly	Three Rivers Community Hospital	25	none	
Houston	Erin	Houston Co. Community Hospital	25	none	
Hickman*	Centerville	St. Thomas Hickman Co. Hospital	25	none	

*\* Only the Dickson, Erin, and Waverly hospitals are in this project's defined primary service area, which in Hickman County includes only zip code 37025. Centerville and most of Hickman County are not in the defined service area. The Centerville hospital is shown as additional information.*

Tennessee Department of Health and THA data show that each year the service area generates almost a thousand births, and several hundred Level II-III cases of NICU care. Table Four-B below shows the past two years of such activity.

<b>Table Four-B: Births and NICU Infants from the Primary Service Area</b>						
<b>Primary Service Area</b>	<b>2012</b>		<b>2013</b>		<b>2014</b>	
	<b>Births</b>	<b>NICU Infants</b>	<b>Births</b>	<b>NICU Infants</b>	<b>Births</b>	<b>NICU Infants</b>
Dickson County	570	179	619	217	625	227
Humphreys County	219	52	198	69	187	50
Houston County	74	18	73	29	96	34
Zip Code 37025 in Hickman County	73	23	89	23	79	23
<b>Totals</b>	<b>936</b>	<b>272</b>	<b>979</b>	<b>338</b>	<b>987</b>	<b>334</b>
NICU Infants as % of Births		29.1%		34.5%		33.8%

*Source: TDH for county births; THA for zip code births; THA for NICU DRG's.*

This birth and NICU data for YTD 2015 is not yet available for the entire service area. However, TriStar Horizon's physicians have steeply increased Horizon's own neonatal transfers to Level II care in CY2015. This is largely due to a nationwide change in neonatal care practice triggered by a 2015 study in the Journal of the American Medical Association (see Attachments). The study looked at fourth grade achievement test scores of newborns who had persistent low blood sugar levels (hypoglycemia) following their births. The pediatric community now believes that the duration of newborn hypoglycemia may affect cognitive abilities later in the child's life.

In the past, Level I units typically kept hypoglycemic infants up to two days to stabilize their blood sugar levels. But within the past year, Level I units like Horizon's have initiated neonatal transport to a Level II NICU for more rapid resolution of the problem, if the newborn's hypoglycemia cannot be normalized/stabilized on-site within 12 hours of birth. The bullets below illustrate the changed landscape for this service within the past year. They are graphically illustrated on the following four pages.

- In CY 2014, Horizon transferred 27 neonates to NICU's in the region. In the *first nine months* of CY2015, Horizon has transferred 44 neonates, which annualizes to an estimated 59 transfers by the end of CY 2015 (of which 52 will be for Level II care). This will be more than a doubling of transfers in less than a year's time.
- Transfers for Level II care have increased steadily during CY2015. In January there were 2 transfers to Level II care; in April there were 4; in July there were 8.
- In 2015, the total transfers as a percent of births at Horizon increased from 4.3% in January, to 14.3% in May, and to 25.9% in September.
- Year over year, the transfer rate for TriStar Horizon inborns has increased from under 5% in 2012 to approximately 13% in YTD 2015 (Jan-Sep); in September it reached 26%.

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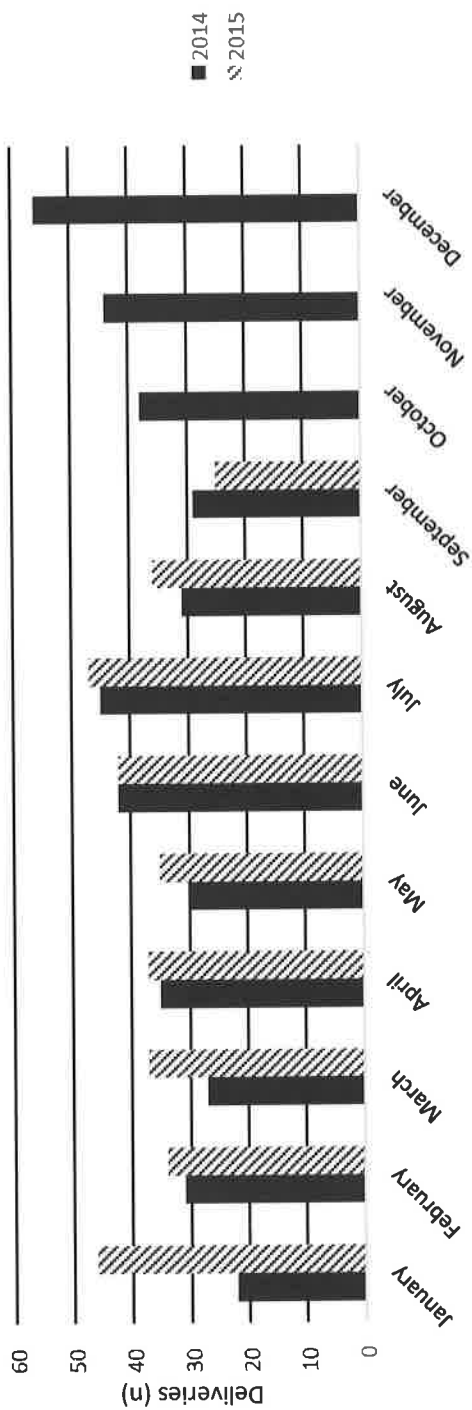
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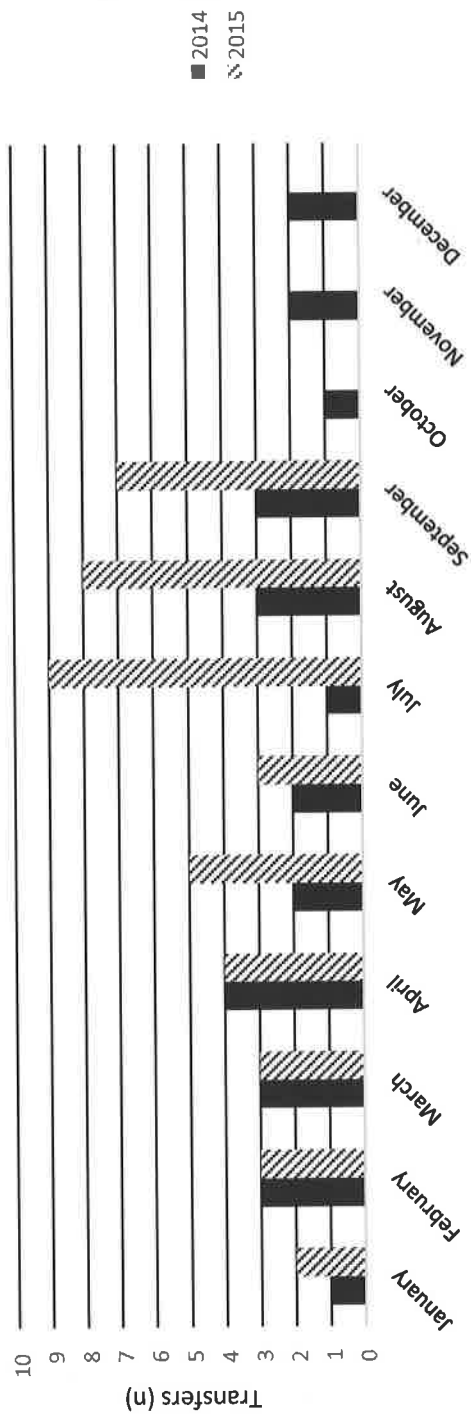
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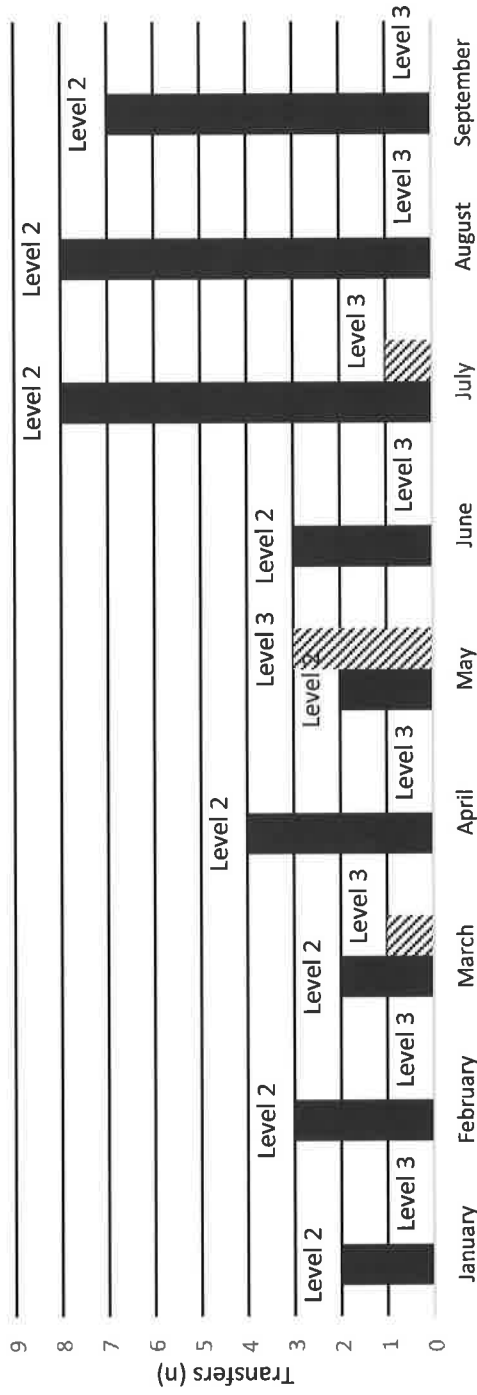
TriStar Horizon - Deliveries by Month



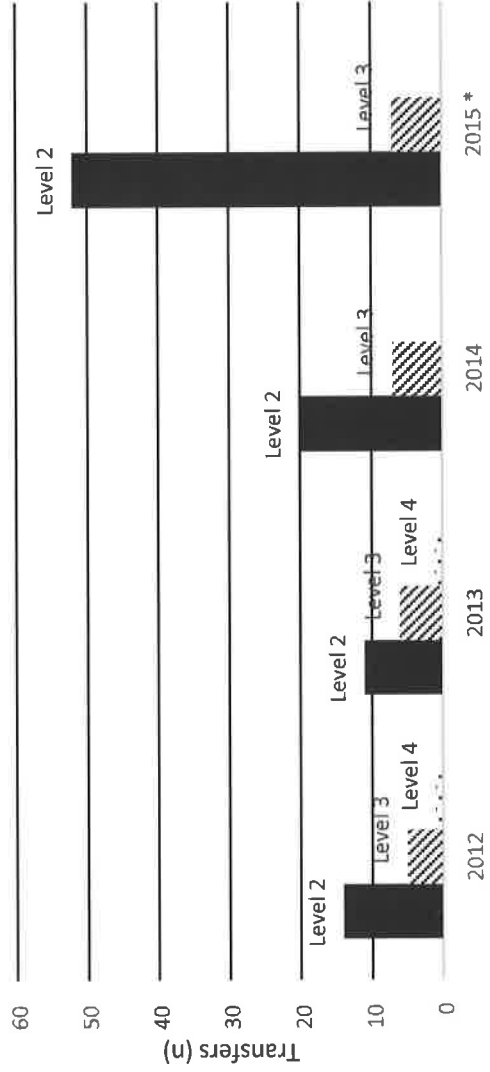
TriStar Horizon - Transfers to a NICU by Month



### TriStar Horizon - 2015 Transfers to a NICU by Month



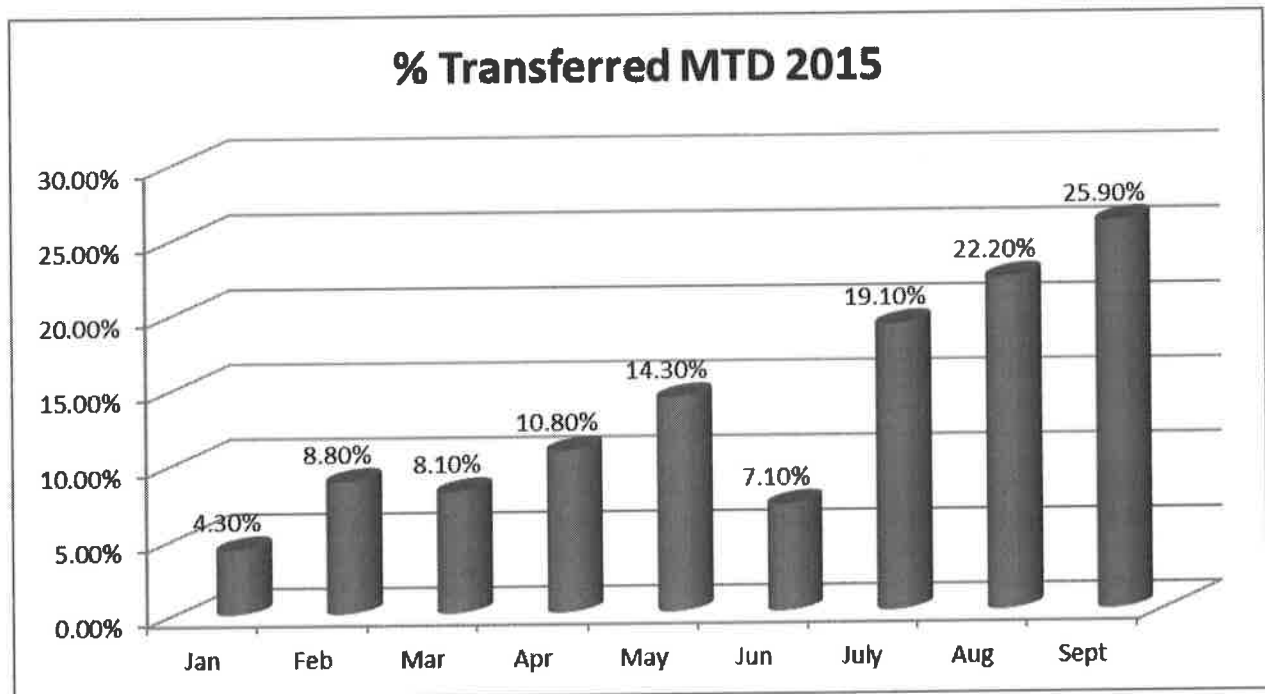
### TriStar Horizon Deliveries - Total NICU Transfers



TriStar Horizon Medical Center

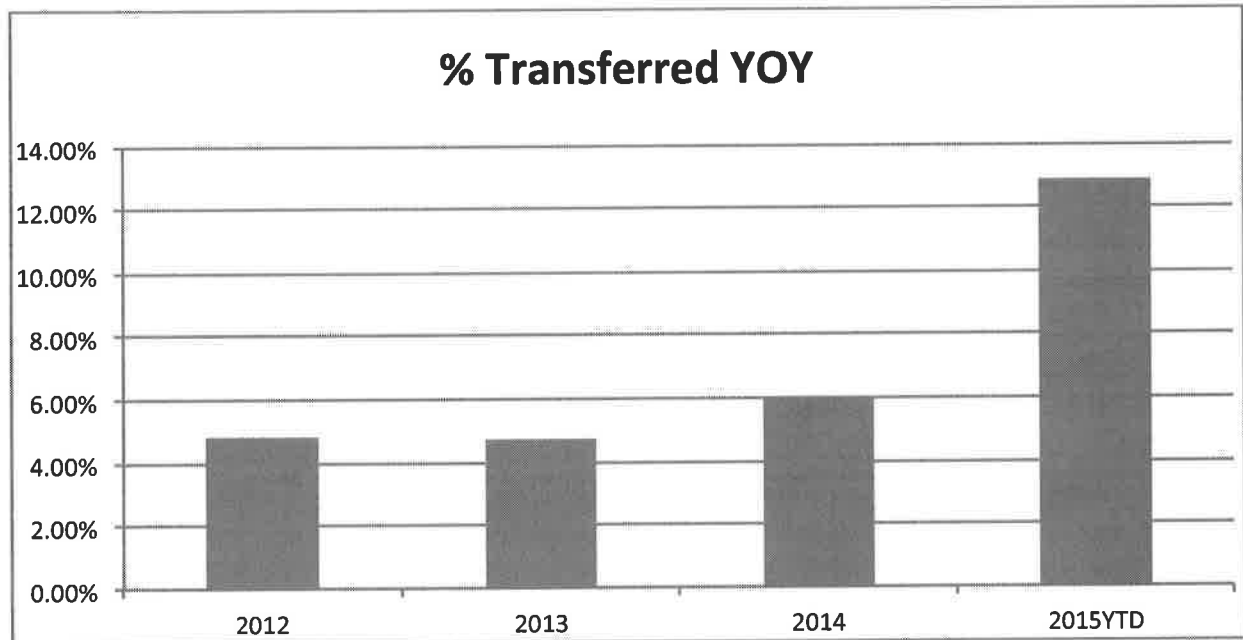
Percent of Newborns Transferred to NICU By Month

YTD 2015



## TriStar Horizon Medical Center

### Percent of Newborns Transferred to NICU By Year 2012-2015



### The Difficulties of Utilizing Out-of-Area Other Programs for Level II Care

These ambulance transfers to remote locations far from the project service area are expensive to the health care system. Above all, they impose major emotional and physical burdens on the families of these infants, who need to visit their baby daily during the average 13-day Level II stay. The drive times and distances to existing Level II programs are very burdensome for persons making daily or frequent round trips to those programs for a period of almost two weeks (which can be three weeks for some).

Table Four-C below illustrates the large reductions in drive time that a Level II program in Dickson will provide to area families. Compared to the five closest Level II NICU's, families coming from the major communities in the service area will save between one and two hours' daily drive time for 15 of the 20 round trips listed; and at least a half hour drive time reduction for the other 5 round trips.

<b>Table Four-C: Round-Trip Drive Times From Service Area Communities To The Project and to the Closest Existing NICU's</b>						
<b>Primary Service Area Community (County)</b>	<b>RT Horizon Med. Center (Dickson)</b>	<b>RT Centennial Med. Center (Nashville)</b>	<b>RT Saint Thomas Midtown (Nashville)</b>	<b>RT Vanderbilt Med. Center (Nashville)</b>	<b>RT Maury Reg'l Med. Center (Columbia)</b>	<b>RT Gateway Med. Center (Clarksv.)</b>
Dickson (Dickson Co.)	8"	1 hr 36 "	1 hr 36 "	1 hr 24"	1 hr 48"	2 hrs 2"
Waverly (Humph. Co.)	1 hr 20"	2 hrs 46 "	2 hrs 46 "	2 hrs 36"	3 hrs	2 hrs 24"
Zip 37025 (Hickman Co.)	38"	1 hr 26"	1 hr 26"	1 hr 4"	1 hr 18"	2 hrs 34"
Erin (Houston Co.)	1 hr 12"	2 hrs 46"	2 hrs 46"	2 hrs 52"	2 hrs 2"	1 hr 42"

*Source: Google Maps.*

### Why the Proposed Level II NICU at Dickson is Needed

In the central area of western Middle Tennessee, north and south of I-40, TriStar Horizon provides the only obstetrics and nursery service between Nashville and Jackson (a distance of 140 miles). The hospital's obstetrics patient origin (shown in a later section of this application) documents the geographically large swath of counties far to the west of Nashville that rely substantially on TriStar Horizon for maternal and infant

care. Hospital and physician letters of support from those counties document the importance to this “sub-region” of having Level II neonatal care available in Dickson.

A Level II designation will actually not require a major change in staffing at the Horizon nursery. Until 2015, Horizon was able to care successfully for area newborns that had low blood sugar problems; the hospital already has neonatal nurse practitioners supervising its nursery care and 24/7 availability of neonatologists. But beginning in 2015, without a formal “Level II” designation (which requires CON approval), Horizon now must transfer such infants to Nashville Level II programs due to the nationwide change in pediatric transfer protocols. Much of the value of this project to service area residents will be to allow TriStar Horizon to resume caring for their babies who have needs that Horizon’s nursery program successfully addressed prior to CY2015. And of course, the Level II program will allow TriStar Horizon to care for some area newborns than it could not care for even prior to 2015.

A Level II designation is essential to the future viability of obstetricians practicing in this area west of Nashville. Increasingly, mothers who are able to travel are choosing to bypass closer obstetrics programs if necessary to reach a program with Level II care, in the event that their infants might need it. Without the Level II designation, the viability of TriStar Horizon’s current program will be steadily eroded and the area may not be able to maintain the number of obstetricians that are currently serving there or are being recruited.

The Level II designation at TriStar Horizon in Dickson will make it easier for service area families to be closer to their infants during the long periods of care required (average length of stay in this Level II unit will be 13 days). Easier access to the care site reduces the emotional burden of separation of a newborn from its parents for prolonged periods. It greatly reduces wearying drive times at a time when strain is heavy on concerned families.

The program upgrade to Level II will also eliminate scores of expensive neonatal transports to Nashville facilities--which mushroomed this year due to the new pediatric transfer protocols for newborns with persistent blood sugar deficiencies. The current average cost of transporting an infant from Horizon to the Centennial NICU in Nashville

and back again is very expensive (the neonatal transport vehicle is dispatched from Nashville and returns to Nashville with the baby). Having a Level II program at Horizon will also allow Horizon's nursery to accept "back-transfers" of infants who are completing a Level III stay in Nashville, and are sufficiently stabilized to be cared for in a less intensive Level II nursery closer to their parents' homes.

**B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.**

Not applicable. The project does not involve any change of location or replacement of facilities.

**B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF \$2.0 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:**

1. For fixed site major medical equipment (not replacing existing equipment):
  - a. Describe the new equipment, including:
    1. Total Cost (As defined by Agency Rule);
    2. Expected Useful Life;
    3. List of clinical applications to be provided; and
    4. Documentation of FDA approval.
  - b. Provide current and proposed schedule of operations.
2. For mobile major medical equipment:
  - a. List all sites that will be served;
  - b. Provide current and/or proposed schedule of operations;
  - c. Provide the lease or contract cost;
  - d. Provide the fair market value of the equipment; and
  - e. List the owner for the equipment.
3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. The project will not require the addition of major medical equipment as defined statutorily and in HSDA rules.

**B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:**

- 1. SIZE OF SITE (IN ACRES);**
- 2. LOCATION OF STRUCTURE ON THE SITE;**
- 3. LOCATION OF THE PROPOSED CONSTRUCTION; AND**
- 4. NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

**PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.**

See Attachment B.III.A.

**B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.**

The project will be on the second floor of TriStar Horizon Medical Center, located in Dickson, Tennessee on Highway 70 East, one block east of its intersection with Highway 46. The hospital has been at that location for decades and is well known to residents of the project service area, who are generally within 45 minutes' drive of the hospital. Service area residents coming from outside Dickson County can reach TriStar Horizon Medical Center by way of I-40 (5.5 miles from the hospital via Highway 46), Highway 49/46 (from Erin), Highway 46 (from north Hickman County), and Highway 70 (from Waverly). Dickson County residents can reach the hospital in Dickson by more than four State and county highways.

Table Five-A below shows the drive times and distances between the project and the major communities in the primary service area, and comparable drive times and distances to the closest existing NICU's north, east, and south of the project. To highlight the real accessibility issue for families making daily trips to a NICU to be with their infants, Table Five-B on the following page shows *round-trip* drive times for those points. TriStar Horizon's NICU will provide significant improvement in round-trip drive times for service area residents--between one to two hours drive time reduction for 15 of the 20 current options; a half hour or more drive time reduction for all the other options.

<b>Table Five-A: One-Way Distances and Drive Times From Service Area Communities To The Project and to the Closest Existing NICU's</b>												
Primary Service Area Community (County)	To Horizon Med. Center (Dickson)		To Centennial Med. Center (Nashville)		To Saint Thomas Midtown (Nashville)		To Vanderbilt Med. Center (Nashville)		To Maury Reg'l Med. Center (Columbia)		To Gateway Med. Center (Clarksville)	
	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min
Dickson (Dickson Co.)	0.9	4"	39.7	48"	39.8	48"	37.8	42"	41.3	54"	40.5	62"
Waverly (Humph. Co.)	29.3	40"	68.1	83"	68.2	83"	66.3	78"	69.7	90"	52.5	72"
Centerville (Hickman Co.)	28.7	43"	58.3	68"	58.4	68"	56.5	63"	29.6	38"	68.3	104"
Erin (Houston Co.)	29.6	41"	68.4	83"	74.3	83"	75.0	86"	70.1	91"	34.2	51"

Source: Google Maps.

<b>Table Five-B: Round-Trip Drive Times From Service Area Communities To The Project and to the Closest Existing NICU's</b>						
<b>Primary Service Area Community (County)</b>	<b>RT Horizon Med. Center (Dickson)</b>	<b>RT Centennial Med. Center (Nashville)</b>	<b>RT Saint Thomas Midtown (Nashville)</b>	<b>RT Vanderbilt Med. Center (Nashville)</b>	<b>RT Maury Reg'l Med. Center (Columbia)</b>	<b>RT Gateway Med. Center (Clarksville)</b>
Dickson (Dickson Co.)	8"	1 hr 36 "	1 hr 36 "	1 hr 24"	1 hr 48"	2 hrs 2"
Waverly (Humph. Co.)	1 hr 20"	2 hrs 46 "	2 hrs 46 "	2 hrs 36"	3 hrs	2 hrs 24"
Zip 37025 (Hickman Co.)	38"	1 hr 26"	1 hr 26"	1 hr 4"	1 hr 18"	2 hrs 34"
Erin (Houston Co.)	1 hr 12"	2 hrs 46"	2 hrs 46"	2 hrs 52"	2 hrs 2"	1 hr 42"

*Source: Google Maps.*

**B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.**

See attachment B.IV.

**IV. FOR A HOME CARE ORGANIZATION, IDENTIFY**

- 1. EXISTING SERVICE AREA (BY COUNTY);**
- 2. PROPOSED SERVICE AREA (BY COUNTY);**
- 3. A PARENT OR PRIMARY SERVICE PROVIDER;**
- 4. EXISTING BRANCHES AND/OR SUB-UNITS; AND**
- 5. PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

**C(I) NEED**

**C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.**

**A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.**

**B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).**

**Project -Specific Review Criteria: Neonatal Intensive Care Unit**

***(Current Guidelines for Growth)***

- 1. The total number of neonatal intensive and intermediate care beds should not exceed eight beds per 1,000 live births per year in a defined neonatal service area.**
- 2. The need shall be based upon the current year's population projected four years forward.**

The following page provides the Tennessee Department of Health's current projection of licensed NICU beds needed for each county in the Middle Tennessee Perinatal Region. The projection is made each year in accordance with these first two CON Guidelines.

TDH projects the following bed needs for counties in this project's primary service area. A 6-bed NICU at this hospital is consistent with the bed need projections for Dickson, Houston, and Humphreys Counties alone (8 beds), without even considering the needs in northern Hickman County.

Dickson County	5 beds
Hickman County	2 beds
Houston County	1 bed
Humphreys County	<u>2 beds</u>
	10 beds

NUMBER OF RESIDENT BIRTHS WITH GENERAL FERTILITY RATES  
(TOTAL BIRTHS-ALL AGES PER 1,000 FEMALES AGED 15-44)  
FOR COUNTIES OF TENNESSEE, RESIDENT DATA, 2014

Sep 8, 2015

COUNTY	TOTAL	
	NUMBER	RATE

Est. 2019 15-44 Pop.	Est. 2019 Births
-------------------------	---------------------

Proj. Bed Needs
--------------------

REGION	34,228	64.9
BEDFORD	640	71.6
CANNON	142	60.0
CHEATHAM	469	63.7
CLAY	74	63.0
COFFEE	693	70.6
DAVIDSON	10,275	65.3
DEKALB	235	70.5
DICKSON	625	66.2
FRANKLIN	399	52.5
GILES	303	59.9
HICKMAN	283	67.5
HOUSTON	96	65.8
HUMPHREYS	187	59.9
JACKSON	90	47.4
LAWRENCE	582	77.7
LEWIS	155	75.7
LINCOLN	339	59.1
MACON	342	78.5
MARSHALL	380	64.5
MAURY	1,130	68.9
MONTGOMERY	3,453	77.9
MOORE	52	48.6
OVERTON	227	60.2
PERRY	121	95.7
PUTNAM	862	57.2
ROBERTSON	884	67.9
RUTHERFORD	4,001	60.0
SMITH	237	69.0
STEWART	130	58.2
SUMNER	2,122	63.9
TROUSDALE	97	65.4
VAN BUREN	61	68.3
WARREN	477	66.4
WAYNE	153	60.9
WHITE	304	67.3
WILLIAMSON	2,149	55.7
WILSON	1,459	62.1

559,818	36,308
9,619	689
2,341	141
7,255	462
1,125	71
10,145	716
163,605	10,682
3,285	232
9,783	647
7,582	398
4,960	297
4,376	295
1,518	100
3,155	189
1,838	87
7,488	582
2,128	161
5,705	337
4,312	338
6,210	401
16,829	1,160
49,798	3,880
1,141	55
3,939	237
1,304	125
16,452	942
14,270	969
77,027	4,621
3,634	251
2,289	133
34,452	2,202
1,553	102
826	56
7,210	479
2,439	148
4,685	315
41,164	2,295
24,376	1,514

290
6
1
4
1
6
85
2
5
3
2
2
1
2
1
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3
3
9
31
0
2
1
8
8
37
2
1
18
1
0
4
1
3
18
12

Current Year Population Estimates Source: Tennessee Department of Health, Division of Policy, Planning and Assessment.

Projections Data Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.

Note: These data will not match the University of Tennessee Data exactly due to rounding.

Report Prepared By: Tennessee Department of Health, Division of Policy, Planning and Assessment.

**3. A single neonatal special care unit shall contain a minimum of 15 beds. This is considered to be the minimum necessary to support economical operation of this service. An adjustment in the number of beds may be justified due to geographic remoteness.**

It should be noted that this is an “economic” criterion that makes assumptions about economic feasibility. It is not a criterion that correlates bed complements with quality of patient care. The financial projections for the unit and the hospital document that this particular 6-bed nursery project, staffed and operated in full compliance with Perinatal Care Guidelines, will be financially feasible. That fact, and the project’s benefits to rural families who live long drives from existing NICU’s, justify the exception offered by this criterion.

**4. The applicant shall designate a specific service area that is compatible with Department of Health guidelines pertaining to this service.**

The application defines a specific primary service area: Dickson, Houston, and Humphreys Counties, and the northern edge of Hickman County in approximately zip code 37025. This primary service area is part of the 37-county Middle Tennessee Perinatal Region designated by the Tennessee Department of Health. The great majority of residents of the defined primary service area are significantly closer to the project site in Dickson than to any existing NICU in counties outside the area.

**5. The applicant should demonstrate the ability to comply with the standards developed in the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing, and Facilities.**

The applicant does and will comply with the standards. A 12-page written response to the Perinatal Care System Guidelines for a Level II Nursery (as set forth in the Seventh Edition 2014) is provided below. It demonstrates that the project will meet or exceed every standard in the Guidelines. Also included in the Attachments to the application are educational and training documents relating to staff competencies and certifications.

The NICU's Medical Director, Dr. Ismail, is a highly-trained, Board-certified Neonatologist whose Fellowship training was at the Medical College of Virginia. He has served for years as the Medical Director of the Level III Nursery and Regional Neonatal Transport Service operated by TriStar Centennial Women's and Children's Hospital in Nashville. His practice group, Pediatrix, directs medical care at five NICU's in the region, through two related Neonatology group practices.

The TriStar Horizon Medical Center NICU will be staffed 24/7 by Pediatrix neonatal nurse practitioners and with NICU-trained RN's. It will comply with staffing ratios in the Perinatal Care Guidelines, which vary with the type of medical care needed by each infant. All staff education and training, and maintenance of staff competencies, will meet or exceed the Guidelines. The unit will work closely with the TriStar Centennial Women's and Children's Hospital NICU in development, staff selection and training, and operations. The TriStar Horizon unit will share in the regional HCA electronic medical records and imaging system, and will have access to telemedicine consultations with physician subspecialists and staff at TriStar Centennial.

**6. The target population shall have access to the proposed service in terms of payment for services, transportation, parking, geographical barriers, and access for the handicapped.**

1. Payment for Services--The unit will be totally financially accessible. TriStar Horizon's policy, like that of the NICU at TriStar Centennial Women's and Children's Hospital, will be to provide all needed NICU care regardless of insurance coverage. It should also be noted that Tennessee newborns who need NICU care have, or can be quickly enrolled in, insurance plans from TennCare or a commercial source.

2. Transportation-- Through its TriStar Centennial Women's and Children's Hospital, HCA operates a region-wide emergency neonatal transport service that can meet neonatal transport needs in the project service area. A vehicle is on call 24/7 and can leave for its destination within 30 minutes of a request. Typically it will carry a neonatal nurse practitioner, a registered nurse, and (if respiratory support may be needed) a respiratory therapist. In addition, TriStar Horizon Medical Center has a helipad for use in air ambulance transports should that be necessary.

3. Parking, Handicapped Access, Geographic Barriers--None of these is an issue at TriStar Horizon Medical Center, which is fully handicapped-accessible with generous surface parking available. No geographic barriers exist within this designated primary service area to impede families or ground or air ambulances reaching the hospital from any point in the service area.

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Following this page is the applicant's 12-page response to how the TriStar Horizon perinatal care program does, and will, conform to the most current (2014) Perinatal Standards referenced in the response to Criterion #5 above. That document will conclude the applicant's response to current CON Guidelines for the project.

However, after that document, the applicant has included a summary response to *draft* TDH Neonatal Care criteria for CON review, which are presently in the State public review and comment period, prior to finalization and incorporation into next year's State Health Plan. The language of these draft standards and criteria are paraphrased by the applicant, for brevity.

TDH says that these draft criteria will not be completed and adopted as part of the State Health Plan in time to apply to this application's review by the HSDA. However, Horizon would like to demonstrate how its proposed Level II program will be in compliance with these new standards, as well as with the currently applicable Guidelines for Growth.

**TRISTAR HORIZON MEDICAL CENTER'S  
PROPOSED LEVEL II NURSERY:  
COMPLIANCE WITH THE TENNESSEE PERINATAL  
CARE SYSTEM GUIDELINES  
FOR LEVEL II NEONATAL FACILITIES  
(Seventh Edition, April 24, 2014)**

**LEVEL II UNITS (DEFINITION)**

Level II nurseries provide specialty neonatal services. They provide care for infants born > 32 weeks gestation and weighing  $\geq$  1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Level II units also have the capability to provide mechanical ventilation for brief durations (< 24 hours) or continuous positive airway pressure.

**Response: The addition of 6 Level II NICU beds to TriStar Horizon Medical Center will meet or exceed the standards of the State Perinatal Care System Guidelines ("Guidelines" in this document).**

**The NICU program will consist of a Level II Special Care nursery with the full range of equipment and staff expertise per Guidelines. Medical direction of neonatal care will be provided by neonatologists (pediatricians board-certified as neonatologists and neonatology/perinatal medicine specialists), and Board-certified neonatal nurse practitioners.**

**The NICU will continue TriStar Horizon Medical Center's philosophy and dedication to Family Centered Care. The nursery will provide parents the opportunity to participate in the care and nurturing of their newborn. We support non-separation of mother and baby because of its many benefits, both short and long term, including facilitation of breast-feeding.**

## LEVEL II FACILITIES - NEONATAL

### I. INTRODUCTION

Level II nurseries provide specialty neonatal services.

Level II units have the capabilities of Level I nurseries, plus:

- Provide care for infants born  $\geq 32$  weeks' gestation and weighing  $\geq$  above 1500 grams, who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.
- Provide mechanical ventilation for brief duration ( $<24$  hrs) or continuous positive airway pressure or both.
- Stabilize infants born at  $<32$  weeks' gestation and weighing  $<1500$  grams until transfer to a neonatal intensive care facility.
- Provide care for infants who are convalescing after intensive care.

(American Academy of Pediatrics *Levels of Neonatal Care*, 2012)

**Complies. TriStar Horizon Medical Center will comply with the above capabilities upon CON approval and addition of six Level II NICU beds.**

### II. SERVICES PROVIDED

#### A. Educational Services

Educational services should include the following:

1. Parent Education: Ongoing perinatal education programs for parents.

**Complies. Comprehensive breastfeeding education programs are provided to the community through certified instructor. A lactation consultant is available 5 days per week. Special printed materials are also available to educate our patients on various pregnancy complications. During the inpatient phase, personalized mother/baby instruction is provided.**

Upon addition of a six bed Level II NICU, all parents taking NICU infants home will be instructed in infant CPR and will room in with their infants at least one night prior to discharge, to become comfortable with assuming routine care responsibilities. They also will receive specialized instruction as needed, e.g., in administering medications, operating home apnea monitors, etc. Comprehensive perinatal education programs will be provided to the community through certified instructors, e.g., preparation for labor, newborn care, sibling classes.

2. Nurse's Education: Programs for nurses that conform to the latest edition of the *Tennessee Perinatal Care System Educational Objectives for Nurses, Level II*, for neonatal nurses, published by the Tennessee Department of Health. These neonatal courses should be made available periodically at Level II facilities by instructors on staff of that institution and/or the staff from a Regional Perinatal Center. Courses may also transpire at a Regional Perinatal Center or at another site remote from the Level II hospital, thus requiring that the hospital provide nurses with educational leave for attendance. Level II hospitals are responsible for the necessary arrangements for nurse education. Nurses caring for infants on mechanical ventilator support in Level II units must be educated according to the guidelines specified for Level III, neonatal.

**Complies.** All nursery RN's are currently required to complete the Perinatal Educational Objectives for Level II nurses and to maintain S.T.A.B.L.E. certification. RN's and RT's maintain certification in neonatal resuscitation and complete comprehensive initial orientation competencies. Continuing education at all levels is provided by the medical staff (neonatologists) and by neonatal nurse practitioners. This includes education and training in breastfeeding.

TriStar Horizon Medical Center is part of the HCA network of hospitals and has the unique opportunity for RN's to utilize education mentoring, shared staffing, policy and protocol resources from HCA's corporate Women's & Children's Department, and from HCA TriStar Level II and Level III nurseries in the Nashville market.

Prior to opening the six bed Level II NICU, the Horizon NICU's RN and Respiratory Therapy staff, and its Ultrasound staff, will receive additional training in the NICU at TriStar Centennial Women's and Children's Hospital's

**Level III neonatal nursery. Under the oversight of Centennial NICU nurses, Horizon RN's and Respiratory Therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II newborns. The RN's will also complete the Level III neonatal course.**

**There will be an NNP (neonatal nurse practitioner) staffed at TriStar Horizon Medical Center 24/7 to provide specialized care and oversight to the NICU patients. The NNP will also provide ongoing patient care oversight, support, and training to the NICU RN's and Respiratory staff.**

3. Physicians' Education: Educational opportunities for physicians should be available upon request, provided by the instructional staff of the Regional Perinatal Center and by qualified individuals on the staff of the Level II institution.

**Complies. At the physician/NNP level, the contracted Neonatologists and Neonatal Nurse Practitioners will complete continuing education courses to maintain certification and keep abreast of new methods and treatments to ensure optimal patient outcomes. The neonatology practice that will lead the unit's patient care is an experienced group of clinicians who maintain their competencies in the 60-bed Level III unit at the TriStar Centennial Women's and Children's Hospital in Nashville.**

4. All neonatal care providers should maintain both current NRP and S.T.A.B.L.E. provider status.

**Complies. All neonatal care providers currently maintain NRP and S.T.A.B.L.E. certification.**

#### **B. Ancillary Services**

1. Laboratory Services: Laboratory capabilities should include but not be limited to the following:

- a. Routine Availability

- Clotting factors
- Serum total protein
- Serum albumin
- Serum IgM
- Serum triglycerides (for parenteral nutrition)

- Metabolic screen
- Liver function tests
- Serologic test for syphilis
- Serology for hepatitis
- Screening for HIV
- TORCH titers
- Viral cultures

b. Available 24 Hours-7 Days Per Week

- Hematocrit
- Hemoglobin
- Complete blood count
- Reticulocyte count
- Blood typing: major groups and Rh
- Cross match
- Minor blood group antibody screen
- Coombs' test
- Prothrombin time
- Partial thromboplastin time
- Platelet count
- Fibrinogen concentration
- Serum sodium, potassium, chloride
- Serum calcium
- Serum phosphorus
- Serum magnesium
- Serum or blood glucose
- Therapeutic drug levels
- Serum bilirubin, total and direct
- Blood gases/pH
- Blood urea nitrogen
- Serum creatinine
- Serum/urine osmolalities
- Urinalysis
- Cerebrospinal fluid: cells, chemistry
- Bacterial cultures and sensitivities
- C-reactive protein (CRP)
- Gram stain
- Toxicology
- Group B strep screening

**Complies. TriStar Horizon Medical Center currently has all of these testing capabilities available.**

2. Blood Bank Services: Blood bank services should be maintained at all times. An appropriately trained technician should be in-house 24 hours daily. All blood components must be available on an emergency basis, either on the premises or by pre-arrangement with another facility.

**Complies. TriStar Horizon Medical Center currently has this service available.**

#### C. Consultation and Transfer

The Level II facilities should maintain an active relationship with a Level III or Level IV facility in the region for consultation and transfer. Protocols for transport should conform to the most recent edition of the *Tennessee Perinatal System Guidelines on Transportation*, published by the Tennessee Department of Health.

Neonatal Consultation and Transport: When the severity of an illness requires a level of care that exceeds the capacity of the Level II facility, the infant should be transferred to a Level III institution capable of providing required care. Transport of these infants should be provided after consultation with the receiving Level III or Level IV unit. Refer to the most recent edition of the *Tennessee Perinatal Care System Guidelines on Transportation*, published by the Tennessee Department of Health, for more information.

**Complies. TriStar Horizon Medical Center currently has transfer relationships with a Level III and a Level IV facility within Middle Tennessee (TriStar Centennial Medical Center and Vanderbilt University Medical Center, respectively). These facilities are prepared to accept neonatal transports if the newborn's condition requires a higher level of care. All newborns transported from Horizon will be evaluated by a neonatal care provider prior to transport. Transfers occur routinely at the present time, in conformity to the *Tennessee Perinatal Care System Guidelines on Transportation*.**

#### D. Maintenance of Data

The following items represent the minimum information that should be in medical records maintained at Level II facilities.

- Name, gender, hospital medical record number
- Date of birth

- Birthweight
- Gestational age
- Apgar scores (per current NRP guidelines)
- Maternal complications (test results relevant to neonatal care; maternal illness potentially affecting the fetus; history of illicit substance use or any other known socially high-risk circumstances; complications of pregnancy associated with abnormal fetal growth, fetal anomalies, or abnormal results from tests of fetal well-being; information regarding labor and delivery; and situations in which lactation may be compromised)
- Discharge diagnosis
- Special care administered (specify)
- Documentation of newborn metabolic, hearing and critical congenital heart disease (CCHD) screens, and immunizations and medications given
- Bilirubin screen (according to American Academy of Pediatrics guidelines)
- Disposition
  - Discharged home
  - Transferred to a higher level of care / Receiving hospital / Transport service
  - Expired

**Complies. TriStar Horizon Medical Center currently maintains all of the documentation listed above in the patient's medical record.**

### III. PERSONNEL: QUALIFICATIONS AND FUNCTIONS

Requirements for adequate staffing are based upon the assumption that patients will be transferred to a Level III or Level IV facility when their illnesses necessitate a level of care that exceeds the capability of Level II facilities. Level II facilities must have the personnel (e.g. physicians, specialized nurses, respiratory therapists, radiology technicians, laboratory technicians) and equipment (e.g., portable chest radiograph, blood gas laboratory) continuously available to provide ongoing care as well as to address emergencies. When the unit has an infant on a ventilator, specialized personnel must be available on site to manage respiratory emergencies.

## A. Physicians

1. In a Level II hospital, a board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine should be chief of the neonatal care service.

**Complies.** Dr. Sami Ismail, board certified neonatologist with Pediatrix, one of the region's largest neonatology organizations, is currently the Medical Director of TriStar Horizon's Level I nursery. He has served as the Medical Director for the nursery since 2005. Upon the addition of a six-bed Level II NICU, he will continue to serve as Medical Director. Dr. Ismail joined the medical staff of Centennial Medical Center in 1989 as the Director of Neonatology. He continues to maintain that position. The following is a list of positions that he has held:

- Director of 60-bed Newborn Intensive Care Unit at TriStar Centennial Women's and Children's Hospital
- Director of Centennial's NICU Regional Transport Services
- Director of Neonatal Nurse Practitioner Program
- President of Mid-TN Neonatology Associates
- Medical Director of Pediatrix Medical Group of TN
- Board of Trustees for Centennial Medical Center

2. The co-directors of perinatal services should coordinate the hospital's perinatal care services and, in conjunction with other medical, anesthesia, nursing, respiratory therapy, and hospital administration staff, develop policies concerning staffing, procedures, equipment, and supplies. The medical directors of obstetrics and neonatology are responsible for setting the hospital's standard of perinatal care by working together to incorporate evidence-based practice patterns and nationally recognized care standards.

**Complies.** TriStar Horizon Medical Center has a very involved medical staff that consistently and routinely participates in setting our standards of perinatal care. They are very active participants in committees and policy development. TriStar Horizon Medical Center is part of the HCA network of hospitals and has the unique opportunity for MD's to utilize education, mentoring, consultation, policy and protocol resources from the HCA corporate Women's & Children's department as well as from HCA TriStar hospitals in the Nashville market.

3. Every delivery should be attended by at least one person whose primary responsibility is for the newborn and who is capable of initiating neonatal resuscitation according to the American Heart Association and American Academy of Pediatrics Neonatal Resuscitation Program guidelines. Either that person or someone else who is immediately available should have the skills required to perform a complete resuscitation, including endotracheal intubation and administration of medications.

**Complies. TriStar Horizon Medical Center meets this requirement. All RN's and Respiratory Therapists are required to maintain NRP provider status per guidelines set forth by the AAP and the AHA. Two RN's attend every vaginal delivery. A neonatology nurse practitioner (NNP), two RN's, a CRNA, and an MD anesthesiologist attend all C/Sections.**

**TriStar Horizon Medical Center employs 3 RN's in Women's Services who are NRP instructors. They are responsible for resuscitation competency monitoring and mentoring.**

**Upon the addition of a six-bed Level II NICU, there will be an NNP and NICU-RN on-site 24/7 to attend deliveries of infants requiring extensive resuscitation or continued specialized care.**

4. Deliveries of high-risk fetuses should be attended by an obstetrician and at least two other persons qualified in neonatal resuscitation whose only responsibility is the neonate. With multiple gestations, each newborn should have his or her own dedicated team of care providers who are capable of performing neonatal resuscitation according to the American Heart Association and American Academy of Pediatrics Neonatal Resuscitation Program guidelines.

**Complies. TriStar Horizon Medical Center currently meets this requirement. Two RN's and an NNP attend all high risk deliveries. A Respiratory Therapist will attend any high risk delivery upon request. Multiple gestations have a dedicated team of care providers for each infant. Upon the addition of a six bed NICU, there will be an NNP, NICU-RN and Respiratory Therapist in-house 24/7 to attend all high risk deliveries.**

#### **B. Nurses**

1. The nurse manager (RN) is responsible for all nursing activities in the nurseries of Level II facilities. The nurse manager in a

hospital with a Level II nursery must complete the Level II neonatal courses prescribed for staff nurses in the most recent edition of the *Tennessee Perinatal Care System Education Objectives for Nurses, Level II*, published by the Tennessee Department of Health.

**Complies.**

2. All staff nurses (RN) must be skilled in observation and treatment of sick infants. For Level II facilities they must complete the Level II neonatal course for nurses outlined in the most recent edition of the *Tennessee Perinatal Care System Educational Objectives for Nurses*, published by the Tennessee Department of Health. Nurses should maintain institutional unit-specific competencies. In addition, all nurses should be current NRP and S.T.A.B.L.E. providers.

**Complies.** All nursery staff have completed unit-specific competencies, as well as the neonatal course outlined in the *Tennessee Perinatal Care System Educational Objectives for Nurses (Fourth Edition)*. They are current providers for the Neonatal Resuscitation Program and the STABLE Program.

**TriStar Horizon Medical Center employs 3 RN's in Women's. Services who are NRP instructors. They are responsible for NRP instruction as well as for resuscitation competency monitoring and mentoring.**

**Prior to the addition of a six-bed Level II NICU, the NICU-RN's and Respiratory Therapists will receive additional training in the NICU at TriStar Centennial Women's and Children's Hospital. Under the oversight of NICU nurses at TriStar Centennial Women's and Children's Hospital, the RN's and Respiratory Therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II newborns. The RN's will also complete the Level III neonatal course.**

**There will be an NNP (neonatal nurse practitioner) staffed at TriStar Horizon Medical Center 24/7 to provide specialized care and oversight to the NICU patients. The NNP will also provide ongoing support and training to the NICU-RN's and Respiratory staff.**

1. Recommended Registered Nurse (RN) / Patient Ratios for Newborn Care (Association of Women's Health, Obstetric, and Neonatal Nurses *Guidelines for Professional Registered Nurse Staffing for Perinatal Units*, 2010):

<b>Ratio</b>	<b>Care Provided</b>
1:5-6	Newborns requiring only routine care
1:3-4	Newborns requiring continuing care
1:2-3	Newborns requiring intermediate care
1:1-2	Newborns requiring intensive care
1:1	Newborns requiring multisystem support
1 or more:1	Unstable newborns requiring complex critical care

**Complies. TriStar Horizon Medical Center meets and exceeds the nurse/patient ratios as outlined for Level I care. With the addition of six Level II NICU beds, TriStar Horizon Medical Center will meet the above nurse/patient ratios.**

#### C. Respiratory Therapists

Respiratory Therapists who can provide supplemental oxygen, assisted ventilation, and continuous positive pressure ventilation (including high flow nasal cannula) of neonates with cardiopulmonary disease should be continuously on site to provide ongoing care as well as to address emergencies.

**Complies. TriStar Horizon Medical Center complies with this requirement. Prior to the addition of a six-bed Level II NICU, Horizon's Respiratory Therapists will receive additional training in the NICU at TriStar Centennial Women's and Children's Hospital. Under the oversight of NICU Respiratory Therapists at TriStar Centennial Women's and Children's, Horizon Respiratory Therapists will complete an initial orientation and will receive ongoing training until they achieve the competencies required to care for Level II newborns.**

**There will be an NNP (neonatal nurse practitioner) staffed at TriStar Horizon Medical Center 24/7 to provide specialized care and oversight to the NICU patients. The NNP will also provide ongoing support and training to the Respiratory staff.**

#### D. Social Services / Case Management

Personnel experienced in dealing with perinatal issues, discharge planning and education, follow-up and referral, home care planning, and bereavement support should be available to intermediate and intensive care unit staff members and families.

**Complies. TriStar Horizon Medical Center already has personnel with these listed skills and experience. Case managers and social workers will also be oriented to their expanded roles through an internship at TriStar Centennial Women's and Children's Hospital NICU.**

#### E. Dietitian/Lactation Consultant

The staff must include at least one dietitian who has special training in perinatal nutrition and can plan diets that meet the needs of high risk neonates. Availability of lactation consultants 7 days a week is recommended to assist with complex breastfeeding issues. 1.6 full-time equivalent lactation consultants are recommended for every 1,000 births based on an annual birth volume in Level II perinatal centers (Association of Women's Health, Obstetric, and Neonatal Nurses *Guidelines for Professional Registered Nurse Staffing for Perinatal Units*, 2010).

**Complies. TriStar Horizon Medical Center meets, and will continue to meet, this requirement. In addition, TriStar Horizon's nurses in this area are trained to fill in for the lactation consultant if necessary.**

#### F. Pharmacist

A registered pharmacist with expertise in compounding and dispensing medications, including total parenteral nutrition (TPN) for neonates must be available 24 hours per day.

**Complies. TriStar Horizon Medical Center meets this requirement.**

#### IV. SPACE AND EQUIPMENT FOR LEVEL II FACILITIES

- A. Physical facilities and equipment should meet criteria published in the latest edition of the *Guidelines for Perinatal Care*, jointly published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

**Complies. TriStar Horizon Medical Center complies with this requirement.**

- B. Minimal equipment for care of the normal infant includes:

1. A platform scale, preferably with metric indicators.
2. A controlled source of continuous and/or intermittent suction.
3. Incubators and/or radiant warmers for adequate thermal support.
4. Equipment for determination of blood glucose at the bedside.
5. Ability to perform intensive phototherapy.
6. A device for the external measurement of blood pressure from the infant's arm or thigh.
7. Oxygen flow meters, tubing, binasal cannulas for short-term administration of oxygen.
8. A headbox assembly (oxygen hood), an oxygen blending device, and a warming nebulizer for short-term administration of oxygen.
9. An oxygen analyzer that displays the ambient concentration of oxygen.
10. A newborn pulse oximeter for non-invasive blood oxygen monitoring.
11. An infusion pump that can deliver appropriate volumes of continuous fluids and/or medications for newborns.
12. A fully equipped neonatal resuscitation card.
13. Positive pressure ventilation equipment and masks; endotracheal tubes in all the appropriate sizes for neonates.
14. A laryngoscope with premature and infant size blades.
15. A CO<sub>2</sub> detector.
16. Laryngeal mask airway (LMA, size 1)

**Complies. TriStar Horizon Medical Center has all of the equipment listed above available for every newborn.**

### C. Intermediate Care Nursery

Additional equipment needed for intermediate care newborns include:

1. A servo-controlled incubator or heated open bed for each infant who requires a controlled thermal environment.
2. Cardiorespiratory monitors that include pressure and waveform monitoring.
3. Oxygen analyzers, blenders, heaters, and humidifiers sufficient for anticipated census.
4. A sufficient number of head box assemblies (oxygen hoods).
5. Modes of respiratory support: binasal cannulas, conventional mechanical ventilator, mechanism to delivery nasal CPAP.
6. A bag or t-piece resuscitator and mask for each infant.
7. An adequate supply of endotracheal tubes and other intubation supplies and LMA.
8. A device for viewing x-rays in the infant area.

**Complies. TriStar Horizon Medical Center currently has all of the above equipment for its current Level I program. Additional equipment of this type will be purchased upon approval of the CON and addition of six NICU beds.**

**TENNESSEE STATE HEALTH PLAN  
PROPOSED DRAFT REVIEW CRITERIA  
FOR  
A NEONATAL INTENSIVE CARE UNIT**

- 1. Determination of Need:** The draft directs that the NICU bed needs be based on a three-year rather than a four-year population projection, although four years has been the normal planning horizon for most CON criteria for many years. *The applicant does not know if this would significantly affect the county-level NICU bed needs projected for this service area currently. It likely would not change the conclusion of applying this criterion, because the current formula indicates a 10-bed need while the project is only for 6 beds.*
- 2. Minimum Volume Standard:** The draft recommends that a Level II unit be at least 10 beds rather than the current 15--but it still states that this is “necessary to support economical operation of these services”, and still offers applicants an exception if justified by geographic remoteness. *This application would qualify for the exception.*
- 3. Establishment of Service Area:** The draft requires that the service area designation be reasonable and based on an optimal balance between population density and service proximity of the applicant. *This application appears to comply with this new general language.*
- 4. Access:** The draft requires that the applicant must be willing and able to serve the entire designated service area, and gives special consideration to situations of limited access within the proposed service area. *This application clearly demonstrates accessibility issues for service area residents, who do not now have acceptable access to Level II neonatal nursery care.*
- 5. Orderly Development of Applicant’s Neonatal Nursery Services:** The draft asks that the applicant document the number of Level II, III, and IV neonatal transfers from its nursery over the last three years. *The applicant has provided several years of that data in this application with regard to the last two years.*

**6. Occupancy Rate Consideration:** *Not applicable. This draft criterion pertains to expanding an existing NICU or establishing one within a service area where NICU's already exist. This project does neither.*

**7. Assurance of Resources:** This new criterion asks that applicants document their ability and commitment to conform to the Perinatal Guidelines, including a letter from the applicant's Governing Board affirming that commitment and ability, and including proof of financial resources to sustain such a service at a high level of quality. *This project certainly meets all aspects of this criterion, though no Board letter is yet required in the CON review process.*

**8. HSDA consultation with the Perinatal Advisory Committee** is required in CON review. *This is already being done in the current CON program.*

**9. Adequate Staffing:** This long draft criterion basically requires applicants to document that their intended staffing, supervision, and training plans are feasible and that they will comply with the Perinatal Guidelines. *This application complies with these requirements.*

**10. Staff and Service Availability for Emergent Cases:** The draft requires that the neonatologist(s) be able to "mobilize" rapidly for emergency cases, 24/7. *This project will comply.*

**11. Education:** The draft requires details of education plans for physicians, staff, and parents, in accordance with the Perinatal Guidelines. *This application has provided extensive documentation of its plans.*

**12. Clinical Guidelines:** The draft asks applicants to document current and future compliance with the Perinatal Guidelines. *The applicant has done that in this application with respect to the Seventh Edition (2014) of those Guidelines.*

**13. Community Linkage Plan:** Applicants should describe any community linkage plan that will be in place in this project. *As attested by support letters from other hospitals and physicians in the area, the applicant has worked with other providers in the*

*region to make them aware of this proposed improvement so that detailed coordination plans can be put in place once the unit is under development.*

**14. Data Requirements:** This criterion asks that applicants agree to furnish appropriate and timely information and statistics on this service to the TDH and the HSDA. *The applicant will do this; and an existing section of the application asks for essentially the same commitment (which has been made).*

**15. Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. *The applicant has all these in place already. Current application and Guidelines do not require such redundant documentation but the applicant will comply with this when it is adopted.*

**16. Tennessee Initiative for Perinatal Quality Care (TIPQC):** The applicant is encouraged to include a description of its plan to participate in this. *Both TriStar Horizon Medical Center and TriStar Centennial Women's and Children's Hospital, which is mentoring Horizon in this project, participate in this initiative. Horizon participated in the "No Elective Deliveries Prior to 39 Weeks" initiative, and Horizon staff regularly participate in TIPQC OB Webinars and conference calls on Perinatal Quality Initiatives and in regional learning sessions. TriStar Centennial Women's and Children's has been involved in TIPQC from its inception. Their previous and current TIPQC projects have included work on Admission Temperatures, the "No Elective Deliveries Prior to 39 Weeks" initiative, CLABSI, human milk for the NICU, family involvement in the NICU, Golden Hour, Neonatal Abstinence Syndrome (NAS), and Breastfeeding Promotion.*

# **The Framework for Tennessee's Comprehensive State Health Plan**

## **Five Principles for Achieving Better Health**

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

### **1. Healthy Lives**

***The purpose of the State Health Plan is to improve the health of Tennesseans.***

**Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.**

The Level II NICU program for this hospital has been developed and will be implemented and operated in collaboration with the Level III program at TriStar Centennial Women's and Children's Hospital, a 60-bed NICU that is the second largest in Middle Tennessee, and the hub for a regional Perinatal Transport team.

### **2. Access to Care**

***Every citizen should have reasonable access to health care.***

**Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.**

This project addresses the issue of geographic access to neonatal care for residents of a rural area, most of which is more than an hour's drive from existing Level II nurseries north, east, and south of the project site. The project will improve their access to newborn care; and it will also allow mothers in this area to remain close to their infants when the infants need brief Level II care before going home.

### **3. Economic Efficiencies**

***The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.***

The project develops high quality newborn care in a rural area that is now too far from such care. It makes it more efficient for families to be with their newborns who may require Level II care. It significantly reduces the costs of neonatal transport for infants who are born with Level II needs at TriStar Horizon Medical Center, and now are being moved to Nashville NICU's for lack of the Level II program in Dickson.

### **4. Quality of Care**

***Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.***

TriStar hospitals such as Horizon Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

### **5. Health Care Workforce**

***The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.***

This project will not affect the health care workforce to any significant degree.

**C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.**

TriStar Horizon Medical Center, because of geography, has a unique role in the development of acute care services in western Middle Tennessee, between Nashville and the Tennessee River.

Within this "sub-region", TriStar Horizon is the only hospital of any significant size and scope, in a very large region of western Middle Tennessee on both sides of I-40. The only other hospitals in this project's service area--in Erin (Houston County), Waverly (Humphreys County), and Centerville (Hickman County) are small 25-bed facilities, Critical Access Hospitals, with few services and small medical staffs.

By contrast, TriStar Horizon Medical Center is located in this region's largest population center and fastest-growing area, on its principal east-west highway corridors (I-40 and Highway 70). For more than a decade, Horizon has been developing into a "sub-regional" acute care resource for this area. Horizon offers a wide range of services on both its main campus in Dickson, and a satellite outpatient campus on I-40: a dedicated ambulatory surgery center, a dedicated outpatient diagnostic center, radiation therapy, a main campus and satellite campus Emergency Department, and a busy obstetrics service and nursery. In time, with CON approval, the existing hospital in downtown Dickson plans to relocate to its satellite campus on I-40, for even greater accessibility and visibility.

In the area of obstetrics, this project is the next logical and appropriate step in expanding the scope and quality of care for mothers and infants in the service area. The hospital is expanding its OB staff, building mutually supportive relationships with other area hospitals, and committing to continued growth in high-quality care for families in this area.

**C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).**

The primary service area of the project will be Dickson County, Houston County, Humphreys County, and zip code 37025 (Bon Aqua) in north Hickman County, which is on the south side of I-40 close to Dickson. The secondary service area will include Perry County and the nearby Fairview area of Williamson County, from which a small number of patients typically come to Dickson for their maternal and infant care. A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

The patient origin of the NICU is projected to reflect the patient origin of maternal admissions to TriStar Horizon Medical Center in 2014--which was almost identical to that of neonates requiring Level II care that year. The table below projects the origin of NICU admissions for this project in its first two years.

<b>Table Six: Projected Patient Origin of TriStar Horizon Medical Center NICU</b>			
<b>County</b>	<b>Percent of Total</b>	<b>Yr 1-2017 NICU Admissions</b>	<b>Yr 2-2018 NICU Admissions</b>
Dickson	52.6%	45	53
Houston	19.4%	16	19
Hickman (Bon Aqua zip code 37025 only)	16.1%	14	16
Humphreys	8.2%	7	8
<i>Subtotals, PSA</i>	96.3%	82	96
Other Counties and Areas	3.7%	3	4
<i>Totals</i>	100.0%	85	100

*Source: 2014 Patient Origin of Maternity Admissions, hospital records*

**C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.**

This rural area has a population of 18,239 women of childbearing age. In 2013, based on the 2010 U.S. Census data (now five years old), the TDH projected that this segment of the service area population will decrease by 1.1% over the next four years while the total area population will increase by 1.5%. The area's median age is higher than the State average.

This is a low-income, high-TennCare service area. Its median household income is \$40,504, which is 8.6% below the Tennessee median household income. Approximately 16.3% of the service area's total population lives below the poverty level; and 23.1% are enrolled in TennCare compared to a State average of 21.8%.

Table Seven on the following page summarizes the demographic characteristics of the area population and identifies the segment (child-bearing age female residents) which this project reflects.

Although it is not yet reflected in State population projections, Dickson County has started to grow significantly since 2010, especially with the recent opening of the western segment of I-840 between I-40 and Williamson County, which provides quicker access to Williamson County's high-growth retail and employment markets in Brentwood, Cool Springs, and Franklin. The growth of Dickson County will likely exceed the expectations of five years ago when TDH population projections were made; and the medical community of Dickson County believes that the child-bearing segment of the population will in fact increase in future years rather than stay level or decline slightly, as projections of five years ago indicated. Births to families in the service area, for instance, increased 5.5% between 2012 and 2014.

**Table Seven: Demographic Characteristics of Primary Service Area, Women of Childbearing Age and Total Population**  
**TriStar Horizon Medical Center NICU**  
**2015-2019**

Primary Service Area	Demographic Characteristics												
	Median Age 2010 Census	Female 15-44 Population 2015	Female 15-44 Population 2019	Female 15-44 Population % Change 2015 - 2019	Total Population 2015	Total Population 2019	Female 15-44 Population % of Total Population 2015	Female 15-44 Population % of Total Population 2019	Median Household Income	TennCare Enrollees 2015	Percent of 2015 Population Enrolled in TennCare	Persons Below Poverty Level 2015	Persons Below Poverty Level as % of Population US Census
County													
Dickson	38.7	9,601	9,554	-0.5%	51,127	52,248	18.8%	18.3%	\$44,318	11,108	21.7%	7,874	15.4%
Houston	41.8	1,453	1,484	2.1%	8,413	8,449	17.3%	17.6%	\$35,271	2,021	24.0%	1,977	23.5%
Hickman	40.0	4,159	3,962	-4.7%	24,465	24,784	17.0%	16.0%	\$39,581	6,295	25.7%	4,257	17.4%
Humphreys	41.9	3,221	3,239	0.6%	18,519	18,581	17.4%	17.4%	\$42,846	4,223	22.8%	2,574	13.9%
PSA	40.6	18,434	18,239	-1.1%	102,524	104,062	18.0%	17.5%	\$40,504	23,647	23.1%	16,682	16.3%
State of Tennessee	38.0	1,306,684	1,337,422	2.4%	6,649,438	6,894,997	19.7%	19.4%	\$44,298	1,447,657	21.8%	229,976	17.6%

Sources: TDH Population Projections, May 2013; U.S. Census Quickfacts; TennCare Bureau.  
PSA data is unweighted average, or total, of county data.

**C(1).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.**

Young families in this area are very far from Level II NICU facilities in Nashville, Clarksville, and Columbia. When their infants are moderately vulnerable or ill, and require this level of care, parents want and need to be close by, not one to two hour round trip drives from their homes and from their other children who also need them. They need a more accessible option than they now have. This project will provide a safe, effective, and much more accessible resource for their infants' care--one which has no insurance or other financial barriers to entry.

This is a need of all income, racial, and ethnic groups of childbearing age in the service area. It is the type of care provided in abundance, at multiple hospital locations, for residents of urban areas like Nashville. TriStar Horizon Medical Center in Dickson is willing, able, prepared, and funded to provide this level of care to residents of these four rural counties, for whom they are already the primary obstetrics and neonatal care provider.

Provision of Level II neonatal care has become essential for most obstetrics providers. Families are demanding it as a safeguard or backup in the event their newborn requires it. Without it available locally, many area mothers are increasingly bypassing their local hospitals. This makes it difficult to retain sufficient birth volumes in the community to ensure continued presence of obstetricians in the community. If rural Tennesseans are to have basic acute care resources--like birth-care--comparable to urban residents, nursery care must be sufficient to maintain the local patient base so that obstetricians will be able to remain in the community to provide OB and gynecological care. This project will ensure that this growing sub-regional medical center west of Nashville continues to thrive and to offer high-quality acute care services to young families.

**C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.**

This project focuses on NICU needs, not obstetrics. The tables below include three years of data on primary service area births and infants having NICU care out of the service area, and three years of utilization data for all NICU's in the Middle Tennessee Perinatal Care Region--a thirty-seven county area comprising all Middle Tennessee Counties.

There are no NICU providers in the primary service area, or within reasonable drive time of the area's population centers. The five existing NICU's that are closest to this project's service area counties are in Tables Five-A and -B earlier in the application. There are three in Nashville (TriStar Centennial, Saint Thomas Midtown; and Vanderbilt), one in Clarksville (Gateway Medical Center); and one in Columbia (Maury Regional).

<b>Table Eight-A: Primary Service Area Births &amp; NICU Infants 2012-2014</b>						
<b>Primary Service Area</b>	<b>2012</b>		<b>2013</b>		<b>2014</b>	
	<b>Births</b>	<b>NICU Infants</b>	<b>Births</b>	<b>NICU Infants</b>	<b>Births</b>	<b>NICU Infants</b>
Dickson County	570	179	619	217	625	227
Humphreys County	219	52	198	69	187	50
Houston County	74	18	73	29	96	34
Zip Code 37025 in Hickman County	73	23	89	23	79	23
<b>Totals</b>	<b>936</b>	<b>272</b>	<b>979</b>	<b>338</b>	<b>987</b>	<b>334</b>
NICU Infants as % of Births		29.1%		34.5%		33.8%

*Source: TDH for county births; THA for zip code births; THA for NICU DRG's.*

Table Eight-B : Utilization of Neonatal Intensive Care Beds (Levels II-B & III) Middle Tennessee Perinatal Region (37 Counties) 2012-2014																		
NICU PROVIDER / HIGHEST LEVEL OF CARE CITY / COUNTY	2012						2013						2014					
	BEDS	ADMISSIONS	DAYS	AVG LENGTH OF STAY	ADC	OCCY	BEDS	ADMISSIONS	DAYS	AVG LENGTH OF STAY	ADC	OCCY	BEDS*	ADMISSIONS	DAYS	AVG LENGTH OF STAY	ADC	OCCY
Vanderbilt Medical Center / III & II-B Nashville / Davidson County	100	1,669	29,611	18	81.1	81.1%	100	1,087	30,669	28	84.0	84.0%	100	1,220	30,577	25	83.8	83.8%
TriStar Centennial Medical Center / III & II-B Nashville / Davidson County	60	1,436	15,446	11	42.3	70.5%	60	662	17,929	27	49.1	81.9%	60	735	19,121	26	52.4	87.3%
St. Thomas Midtown Hospital / III & II-B Nashville / Davidson County	52	439	9,353	21	25.6	49.3%	52	475	10,041	21	27.5	52.9%	52	473	8,348	18	22.9	44.0%
Metro General Hospital / II-B Nashville / Davidson County	10	56	727	13	2.0	19.9%	10	46	370	8	1.0	10.1%	10	57	337	6	0.9	9.2%
TriStar Hendersonville Medical Center / II-B Nashville / Davidson County	10	49	750	15	2.1	20.5%	10	77	1,203	16	3.3	33.0%	10	66	914	14	2.5	25.0%
St. Thomas Rutherford Hospital / II-B Murfreesboro / Rutherford County	16	202	3,048	15	8.4	52.2%	16	234	3,477	15	9.5	59.5%	16	220	3,271	15	9.0	56.0%
TriStar StoneCrest Medical Center / II-B Smyrna / Rutherford County	8	143	902	6	2.5	30.9%	8	202	1,840	9	5.0	63.0%	8	80	1,192	15	3.3	40.8%
Maury Regional Medical Center / II-B Columbia / Maury County	13	214	1,552	7			13	200	1,406	7	3.9	29.6%	13	212	1,583	7	4.3	33.4%
Williamson Medical Center / II-B Franklin / Williamson County	8	137	950	7	2.6	32.5%	8	42	1,154	27	3.2	0.0%	8	63	1,569	25	4.3	53.7%
PERINATAL REGION TOTAL	277	4,345	62,339	14	170.8	61.7%	285	3,075	68,646	22	188.1	66.0%	285	3,355	68,587	20	187.9	65.9%

Sources: TDH Joint Annual Reports.  
Note: TriStar Hendersonville Medical Center is approved to open a 6-bed NICU; scheduled to open in January 2016. Total MTPA NICU beds will be 291.

**C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION...**

The project service area does not contain a NIC. Table Nine-A below shows the applicant's annual deliveries and transfers to NICU's outside the service area. Table Nine-B shows the Levels of NICU care to which those transfers were made. Table Nine-C on the following page provides bed utilization history and projections for the hospital.

TriStar Horizon's annual births have increased at an average annual rate of almost 3% since 2012.

<b>Table Nine-A: TriStar Horizon Medical Center Births and Transfers to NICU's in CY2012-CY2015</b>								
	<b>2012</b>		<b>2013</b>		<b>2014</b>		<b>YTD 2015</b>	
	<b>Births</b>	<b>Transfers to NICU</b>	<b>Births</b>	<b>Transfers to NICU</b>	<b>Births</b>	<b>Transfers to NICU</b>	<b>Births</b>	<b>Transfers to NICU</b>
Jan							46	2
Feb							34	3
Mar							37	3
Apr							37	4
May							35	5
Jun							42	3
Jul							47	9
Aug							36	8
Sept							25	7
Oct							--	--
Nov							--	--
Dec							--	--
YTD	420	20	403	18	430	27	339	44
<b>Annual</b>	<b>420</b>	<b>20</b>	<b>403</b>	<b>18</b>	<b>430</b>	<b>27</b>	<b>452*</b>	<b>59</b>

Source: Hospital records. \*2015 Totals Annualized on Jan-Sep data. NICU transfers include all Levels 2,3,4.

<b>Table Nine-B: TriStar Horizon Medical Center Transfers to NICU's by Level of Care in CY2012-CY2015 Annualized</b>				
<b>NICU Level</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015 Annualized</b>
2	14	11	20	52
3	5	6	7	7
4	1	1	0	0
<b>Totals</b>	<b>20</b>	<b>18</b>	<b>27</b>	<b>59</b>

Source: Hospital records. 2015 annualized on Jan-Sep data.

**Table Nine-C: TriStar Horizon Medical Center**  
**Actual and Projected Licensed Bed Utilization, CY2012-2018**

	Actual 2012	Actual 2013	Actual 2014	Projected 2015	Projected 2016	Year One Projected 2017	Year Two Projected 2018
<b>Total Beds</b>	157	157	157	157	157	157	157
Admissions	4,391	4,533	4,668	5,007	5,107	5,294	5,400
Patient Days	18,099	18,892	19,198	19,929	20,328	21,840	22,277
ALOS on Admissions	4.1	4.2	4.1	4.0	4.0	4.1	4.1
ADC on Admissions	49.6	51.8	52.6	54.6	55.7	59.8	61.0
Occupancy on Admissions	31.6%	33.0%	33.5%	34.8%	35.5%	38.1%	38.9%
23-Hour Observation Days	2,518	2,092	2,422	2,678	2,732	2,787	2,843
Total Bed Days	20,617	20,984	21,620	22,607	23,060	24,627	25,120
Total ADC	56.5	57.5	59.2	61.9	63.2	67.5	68.8
Total Occupancy	36.0%	36.6%	37.7%	39.5%	40.2%	43.0%	43.8%
<b>Medical-Surgical Beds</b>	123	123	123	123	123	117	117
Admissions	3,352	3,439	3,498	3,750	3,807	3,855	3,895
Patient Days	13,527	14,436	14,473	14,666	14,799	14,965	14,999
ALOS on Admissions	4.0	4.2	4.1	3.9	3.9	3.9	3.9
ADC on Admissions	37.1	39.6	39.7	40.2	40.5	41.0	41.1
Occupancy on Admissions	30.1%	32.2%	32.2%	32.7%	33.0%	35.0%	35.1%
23-Hour Observation Days	2,369	1,964	2,279	2,518	2,568	2,619	2,673
Total Bed Days	15,896	16,400	16,752	17,184	17,367	17,584	17,672
Total ADC	43.6	44.9	45.9	47.1	47.6	48.2	48.4
Total Occupancy	35.4%	36.5%	37.3%	38.3%	38.7%	41.2%	41.4%
<b>Intensive/Critical Care Beds</b>	6	6	6	6	6	6	6
Admissions	453	535	565	575	587	600	615
Patient Days	1,719	1,769	1,749	1,840	1,878	1,920	1,960
ALOS on Admissions	3.8	3.3	3.1	3.2	3.2	3.2	3.2
ADC on Admissions	4.7	4.8	4.8	5.0	5.1	5.3	5.4
Occupancy on Admissions	78.5%	80.8%	79.9%	84.0%	85.8%	87.7%	89.5%
23-Hour Observation Days	74	65	73	80	82	84	85
Total Bed Days	1,793	1,834	1,822	1,920	1,960	2,004	2,045
Total ADC	4.9	5.0	5.0	5.3	5.4	5.5	5.6
Total Occupancy	81.9%	83.7%	83.2%	87.7%	89.5%	91.5%	93.4%
<b>Obstetrical Beds</b>	9	9	9	9	9	9	9
Admissions	420	403	430	467	486	515	540
Patient Days	845	810	863	925	972	1,030	1,075
ALOS on Admissions	2.0	2.0	2.0	2.0	2.0	2.0	2.0
ADC on Admissions	2.3	2.2	2.4	2.5	2.7	2.8	2.9
Occupancy on Admissions	25.7%	24.7%	26.3%	28.2%	29.6%	31.4%	32.7%
23-Hour Observation Days	75	63	70	80	82	84	85
Total Bed Days	920	873	933	1,005	1,054	1,114	1,160
Total ADC	2.5	2.4	2.6	2.8	2.9	3.1	3.2
Total Occupancy	28.0%	26.6%	28.4%	30.6%	32.1%	33.9%	35.3%
<b>NICU Beds</b>	0	0	0	0	0	6	6
Admissions	0	0	0	0	0	85	100
Patient Days	0	0	0	0	0	1,105	1,300
ALOS on Admissions	0.0	0.0	0.0	0.0	0.0	13.0	13.0
ADC on Admissions	0.0	0.0	0.0	0.0	0.0	3.0	3.6
Occupancy on Admissions	0.0%	0.0%	0.0%	0.0%	0.0%	50.5%	59.4%
23-Hour Observation Days	0	0	0	0	0	0	0
Total Bed Days	0	0	0	0	0	1,105	1,300
Total ADC	0.0	0.0	0.0	0.0	0.0	3.0	3.6
Total Occupancy	0.0%	0.0%	0.0%	0.0%	0.0%	50.5%	59.4%
<b>Geropsychiatric Beds</b>	7	7	7	7	7	7	7
Admissions	0	0	0	0	0	0	0
Patient Days	0	0	0	0	0	0	0
ALOS on Admissions	0.0	0.0	0.0	0.0	0.0	0.0	0.0
ADC on Admissions	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Occupancy on Admissions	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23-Hour Observation Days	0	0	0	0	0	0	0
Total Bed Days	0	0	0	0	0	0	0
Total ADC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Occupancy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Rehabilitation Beds</b>	12	12	12	12	12	12	12
Admissions	166	156	175	215	227	239	250
Patient Days	2,008	1,877	2,113	2,498	2,679	2,820	2,943
ALOS on Admissions	12.1	12.0	12.1	11.6	11.8	11.8	11.8
ADC on Admissions	5.5	5.1	5.8	6.8	7.3	7.7	8.1
Occupancy on Admissions	45.8%	42.9%	48.2%	57.0%	61.2%	64.4%	67.2%
23-Hour Observation Days	0	0	0	0	0	0	0
Total Bed Days	2,008	1,877	2,113	2,498	2,679	2,820	2,943
Total ADC	5.5	5.1	5.8	6.8	7.3	7.7	8.1
Total Occupancy	45.8%	42.9%	48.2%	57.0%	61.2%	64.4%	67.2%

Note:

### Projection of NICU Admissions

Table Eight-A above showed that the project's primary service area sent 334 infants to NICU care in CY2014. To be conservative, TriStar Horizon projects that its second year NICU admissions will be at least 100 infants, which is equal to 30% of the service area's CY2014 NICU admissions. In the unit's ramp-up first year, its 85 projected admissions would be 85% of that second year volume. There are several reasons why this projection is reasonable.

First, TriStar Horizon Medical Center in Dickson is the sub-regional acute care center for a large rural service area, and offers the area's only wide range of acute care services. It works closely with the two other hospitals in the service area--both of which are 25-bed Critical Access hospitals without obstetrics, and both of which support this proposed nursery upgrade in Dickson. Horizon has two full-time obstetricians and a third is being recruited for CY 2016. It is the logical, and in fact the only possible, location for improved perinatal care in this swath of counties. It is difficult to see how the proposed upgrade of nursing staff competencies and equipment to Level II competencies would not be in the best interest of area families and newborns. The applicant believes that many more service area families will choose TriStar Horizon either for their deliveries, or for their babies' Level II care after birth elsewhere, as they become aware that the Horizon NICU can provide critically important newborn intensive care so much closer to home than it can be obtained in Nashville, Clarksville, or Columbia.

Second, the projected utilization will be attainable because service area demand for newborn Level II admissions appears to be soaring--reflecting more transfers of infants with persistent low blood sugar. During CY 2014, Horizon transferred 20 of its 430 newborns to Level II facilities. Horizon's annualized projection for CY 2015 (based on 10 months' experience) is 52 Level II transfers. That will be a 160% increase over the prior year--with only a 5% increase in annualized births. Data is not yet publicly available to demonstrate that a similar increase in NICU Level II admissions has been experienced by service area mothers who deliver in other hospitals; but it probably has. If so, the demand for NICU admissions from families in this service area will be much larger in CY 2017 than in the past. For example, in CY 2014, service area families had

334 infants in NICU status. If the new transfer policies for low-blood-sugar infants were to increase transfers by 100% (much less than the 160% Horizon has experienced), that would create a service area demand for NICU care of 668 newborns from this service area alone. Serving only 15% of them (100) at TriStar Horizon's Level II NICU, close to their families, would be a readily attainable projection.

#### TriStar Horizon's Licensed Bed Count

The project will be implemented by licensure of six new NICU beds and simultaneous de-licensure of six underutilized medical-surgical beds. So the project will not add licensed beds to the service area.

**C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.**

- **ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST \$3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.**

- **THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.**

- **THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.**

- **FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.**

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1.

On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for expenses of legal assistance during the initial review period through an initial decision by the HSDA .

Line A.5, construction cost, was calculated by the architect and the hospital with the assistance of an experienced contractor utilized by the parent company in this area.

Line A.6, contingency, was estimated by the contractor at 10% of =construction costs in line A.5.

Line A.7 includes both fixed and moveable equipment costs, estimated by the HCA corporate development staff working with OB/Nursery staff of TriStar Horizon.

## PROJECT COSTS CHART-- TRISTAR HORIZON MEDICAL CENTER NICU

### A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees	\$ 30,000
2. Legal, Administrative, Consultant Fees (Excl CON Filing Fee)	30,000
3. Acquisition of Site	0
4. Preparation of Site	0
5. Construction Cost 1,500F @ \$250	375,000
6. Contingency Fund in A.5	37,500
7. Fixed Equipment (Not included in Construction Contract)	0
8. Moveable Equipment (List all equipment over \$50,000)	500,000
9. Other (Specify) _____	0

### B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land)	0
2. Building only	0
3. Land only	0
4. Equipment (Specify) _____	0
5. Other (Specify) _____	0

### C. Financing Costs and Fees:

1. Interim Financing	0
2. Underwriting Costs	0
3. Reserve for One Year's Debt Service	0
4. Other (Specify) _____	0

### D. Estimated Project Cost (A+B+C)

972,500

### E. CON Filing Fee

3,000

### F. Total Estimated Project Cost (D+E)

**TOTAL \$ 975,500**

Actual Capital Cost 975,500  
Section B FMV 0

**C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.**

**a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).**

\_\_\_\_\_ **A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

\_\_\_\_\_ **B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

\_\_\_\_\_ **C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;**

\_\_\_\_\_ **D. Grants--Notification of Intent form for grant application or notice of grant award;**

  x   **E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or**

\_\_\_\_\_ **F. Other--Identify and document funding from all sources.**

The project will be funded by a cash transfer to the applicant, from the parent company, HCA, Inc., through TriStar Health System, the division office to which this hospital belongs. Documentation of financing is provided in Attachment C, Economic Feasibility--2. The income statement and balance sheet of HCA, Inc. are also provided at that location.

**C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.**

The project does not require new construction. It only requires renovation at an estimated cost of \$250 PSF. The cost was estimated by the architect and a consulting contractor familiar with the hospital. This is below the third quartile average costs for hospital renovation projects, as compiled by the HSDA Registry. See Table Two in an earlier section of the application.

**C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).**

See the following pages for these charts, with notes where applicable.

## HISTORICAL DATA CHART -- TRISTAR HORIZON MEDICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.

The fiscal year begins in January.

		2012	2013	2014
	Admissions	4,391	4,533	4,668
	Patient Days	18,099	18,892	19,198
A.	Utilization Data			
B.	Revenue from Services to Patients			
1.	Inpatient Services	\$ 131,364,944	144,330,552	159,908,524
2.	Outpatient Services	73,168,805	81,636,709	87,511,363
3.	Emergency Services	123,734,966	117,181,043	149,938,382
4.	Other Operating Revenue	486,566	540,227	563,658
	(Specify) <u>See notes page</u>			
	<b>Gross Operating Revenue</b>	<b>\$ 328,755,281</b>	<b>\$ 343,688,531</b>	<b>\$ 397,921,927</b>
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	\$ 245,602,262	265,418,399	314,521,768
2.	Provision for Charity Care	4,198,833	3,787,755	4,121,129
3.	Provisions for Bad Debt	10,602,626	7,649,999	10,022,665
	<b>Total Deductions</b>	<b>\$ 260,403,721</b>	<b>\$ 276,856,153</b>	<b>\$ 328,665,562</b>
		<b>\$ 68,351,560</b>	<b>\$ 66,832,378</b>	<b>\$ 69,256,365</b>
	<b>NET OPERATING REVENUE</b>			
D.	Operating Expenses			
1.	Salaries and Wages	\$ 31,408,734	31,428,851	32,559,455
2.	Physicians Salaries and Wages	0	0	0
3.	Supplies	8,822,088	9,018,665	9,417,896
4.	Taxes	560,014	547,037	597,799
5.	Depreciation	3,695,495	3,614,729	3,449,273
6.	Rent	524,189	435,100	380,747
7.	Interest, other than Capital	0	0	0
8.	Management Fees			
a.	Fees to Affiliates	4,258,262	4,606,499	4,653,512
b.	Fees to Non-Affiliates	0	0	0
9.	Other Expenses (Specify) <u>See notes page</u>	19,535,775	18,115,333	17,672,525
	<b>Total Operating Expenses</b>	<b>\$ 68,804,557</b>	<b>67,766,214</b>	<b>68,731,207</b>
E.	Other Revenue (Expenses) -- Net (Specify)	\$ 0	\$ 0	\$ 0
	<b>NET OPERATING INCOME (LOSS)</b>	<b>\$ (452,997)</b>	<b>\$ (933,836)</b>	<b>\$ 525,158</b>
F.	Capital Expenditures			
1.	Retirement of Principal	\$ 0	\$ 0	\$ 0
2.	Interest	3,458,445	3,548,374	3,649,655
	<b>Total Capital Expenditures</b>	<b>\$ 3,458,445</b>	<b>\$ 3,548,374</b>	<b>\$ 3,649,655</b>
	<b>NET OPERATING INCOME (LOSS)</b>			
	<b>LESS CAPITAL EXPENDITURES</b>	<b>\$ (3,911,442)</b>	<b>\$ (4,482,210)</b>	<b>\$ (3,124,497)</b>

Historical Data Chart - Other Revenue & Expense  
TriStar Horizon Medical Center

Other Operating Revenue	2012	2013	2014
Dickson Community Clinic Rent	7,140	6,120	6,120
Education Fees	824	1,811	1,862
Pharmacy Surveys	1,200	3,000	600
Cafeteria	114,155	124,831	130,594
Return Check Fees	0	0	327
Childbirth Education Fees	0	698	198
Vending Machines	2,777	5,596	3,585
Supplies Sales	5,045	2,763	14,787
Miscellaneous	2,984	4,795	9,813
Medical Record Transcription	1,414	500	244
Medical Records Paternity Forms	3,760	3,460	5,180
Medical Staff Application Fees	3,300	3,900	7,700
Physician Office Rent	343,767	382,553	382,448
Automatic Teller Rent	200	200	200
	486,566	540,227	563,658

Other Expenses	2012	2013	2014
Professional Fees	4,011,876	3,861,836	3,368,812
Contract Services	9,659,775	8,348,013	8,482,991
Repairs & Maintenance	2,212,657	2,484,841	2,315,523
Utilities	1,876,952	1,757,177	1,746,147
Insurance	507,030	464,980	489,937
Legal & Audit Fees	43,380	47,640	57,957
Media, Advertising, Gallup Surveys	267,055	261,762	213,374
Postage & Shipping	100,090	87,455	88,706
Travel & Entertainment	118,564	87,349	143,956
Dues & Subscriptions	94,353	114,623	125,519
Physician Recruiting & Guarantees	284,993	197,062	132,383
Professional Dev., Software Licenses	355,774	442,327	539,322
Interest Income & Gain/Loss on Disposals	3,276	-39,732	-32,102
	19,535,775	18,115,333	17,672,525

## PROJECTED DATA CHART-- TRISTAR HORIZON MEDICAL CENTER

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

		2017	2018
	Admissions	5,294	5,400
A.	Utilization Data	21,840	22,277
B.	Revenue from Services to Patients		
1.	Inpatient Services	\$ 200,041,000	\$ 216,044,000
2.	Outpatient Services	107,895,000	116,527,000
3.	Emergency Services	219,132,000	236,663,000
4.	Other Operating Revenue (Specify) <u>See notes page</u>	634,000	659,000
	<b>Gross Operating Revenue</b>	\$ 527,702,000	\$ 569,893,000
C.	Deductions for Operating Revenue		
1.	Contractual Adjustments	\$ 415,678,000	\$ 449,803,000
2.	Provision for Charity Care	5,383,000	5,826,000
3.	Provisions for Bad Debt	16,816,000	18,197,000
	<b>Total Deductions</b>	\$ 437,877,000	\$ 473,826,000
	<b>NET OPERATING REVENUE</b>	\$ 89,825,000	\$ 96,067,000
D.	Operating Expenses		
1.	Salaries and Wages	\$ 38,338,000	\$ 40,912,000
2.	Physicians Salaries and Wages	1,500,000	1,500,000
3.	Supplies	10,350,000	10,764,000
4.	Taxes	675,000	729,000
5.	Depreciation	3,920,000	4,156,000
6.	Rent	494,000	514,000
7.	Interest, other than Capital	0	0
8.	Management Fees		
a.	Fees to Affiliates	5,530,000	5,835,000
b.	Fees to Non-Affiliates		
9.	Other Expenses (Specify) <u>See notes page</u>	20,489,000	21,309,000
	<small>Dues, Utilities, Insurance, and Prop Taxes.</small>		
	<b>Total Operating Expenses</b>	\$ 81,296,000	\$ 85,719,000
E.	Other Revenue (Expenses) -- Net (Specify)	\$	\$
	<b>NET OPERATING INCOME (LOSS)</b>	\$ 8,529,000	\$ 10,348,000
F.	Capital Expenditures		
1.	Retirement of Principal	\$	\$
2.	Interest	3,909,000	3,948,000
	<b>Total Capital Expenditures</b>	\$ 3,909,000	\$ 3,948,000
	<b>NET OPERATING INCOME (LOSS)</b>		
	<b>LESS CAPITAL EXPENDITURES</b>	\$ 4,620,000	\$ 6,400,000

Projected Data Chart - Other Revenue & Expense  
TriStar Horizon Medical Center

Other Operating Revenue	2017	2018
Dickson Community Clinic Rent	0	0
Education Fees	2,100	2,200
Pharmacy Surveys	700	700
Cafeteria	146,900	152,700
Return Check Fees	400	400
Childbirth Education Fees	200	200
Vending Machines	4,000	4,200
Supplies Sales	16,600	17,300
Miscellaneous	11,000	11,500
Medical Record Transcription	300	300
Medical Records Paternity Forms	5,800	6,000
Medical Staff Application Fees	8,700	9,000
Physician Office Rent	437,100	454,300
Automatic Teller Rent	200	200
	634,000	659,000

Other Expenses	2017	2018
Professional Fees	3,654,000	3,800,000
Contract Services	9,782,000	10,173,000
Repairs & Maintenance	2,684,000	2,791,000
Utilities	2,024,000	2,105,000
Insurance	568,000	591,000
Legal & Audit Fees	67,000	70,000
Media, Advertising, Gallup Surveys	297,000	309,000
Postage & Shipping	103,000	107,000
Travel & Entertainment	167,000	174,000
Dues & Subscriptions	145,000	151,000
Physician Recruiting & Guarantees	410,000	426,000
Professional Dev., Software Licenses	625,000	650,000
Interest Income & Gain/Loss on Disposals	-37,000	-38,000
	20,489,000	21,309,000

## PROJECTED DATA CHART-- TRISTAR HORIZON MEDICAL CENTER NICU

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

		2017	2018
	Admissions	85	100
	Patient Days	1,105	1,300
A.	Utilization Data		
B.	Revenue from Services to Patients		
1.	Inpatient Services	\$ 3,796,000	\$ 4,778,000
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue (Specify) <u>See notes page</u>		
	<b>Gross Operating Revenue</b>	\$ 3,796,000	\$ 4,778,000
C.	Deductions for Operating Revenue		
1.	Contractual Adjustments	\$ 1,807,000	\$ 2,371,000
2.	Provision for Charity Care	95,000	119,000
3.	Provisions for Bad Debt	114,000	143,000
	<b>Total Deductions</b>	\$ 2,016,000	\$ 2,633,000
	<b>NET OPERATING REVENUE</b>	\$ 1,780,000	\$ 2,145,000
D.	Operating Expenses		
1.	Salaries and Wages	\$ 908,000	\$ 926,000
2.	Physicians Salaries and Wages	120,000	120,000
3.	Supplies	209,000	255,000
4.	Taxes	5,000	5,000
5.	Depreciation	54,000	54,000
6.	Rent	4,000	4,000
7.	Interest, other than Capital		
8.	Management Fees		
a.	Fees to Affiliates	103,000	124,000
b.	Fees to Non-Affiliates		
9.	Other Expenses (Specify) <u>See notes page</u>	27,000	52,000
	<small>Dues, Utilities, Insurance, and Prop Taxes.</small>		
	<b>Total Operating Expenses</b>	\$ 1,430,000	\$ 1,540,000
E.	Other Revenue (Expenses) -- Net (Specify)	\$	\$
	<b>NET OPERATING INCOME (LOSS)</b>	\$ 350,000	\$ 605,000
F.	Capital Expenditures		
1.	Retirement of Principal	\$	\$
2.	Interest		
	<b>Total Capital Expenditures</b>	\$ 0	\$ 0
	<b>NET OPERATING INCOME (LOSS)</b>		
	<b>LESS CAPITAL EXPENDITURES</b>	\$ 350,000	\$ 605,000

2019-2020

Projected Data Chart - Other Revenue & Expense  
TriStar Horizon Medical Center NICU

Other Expenses	2017	2018
Professional Fees	0	0
Contract Services	5,000	5,000
Repairs & Maintenance	0	25,000
Utilities	0	0
Insurance	0	0
Legal & Audit Fees	0	0
Media, Advertising, Gallup Surveys	20,000	20,000
Postage & Shipping	0	0
Travel & Entertainment	2,000	2,000
Dues & Subscriptions	0	0
Physician Recruiting & Guarantees	0	0
Professional Dev., Software Licenses	0	0
Interest Income & Gain/Loss on Disposals	0	0
	27,000	52,000

**C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.**

<b>Table Ten-A: Average Charges, Deductions, Net Charges, Net Operating Income TriStar Horizon Medical Center NICU</b>		
	<b>CY2017</b>	<b>CY2018</b>
Patient Days	21,840	22,277
Admissions or Discharges	5,294	5,400
Average Gross Charge Per Day (IP+OP)	\$24,162	\$25,582
Average Gross Charge Per Admission (IP+OP)	\$99,679	\$105,536
Average Deduction from Operating Revenue per Day	\$20,049	\$21,270
Average Deduction from Operating Revenue per Admission	\$82,712	\$87,746
Average Net Charge (Net Operating Revenue) Per Day	\$4,113	\$4,312
Average Net Charge (Net Operating Revenue) Per Admission	\$16,967	\$17,790
Average Net Operating Income after Expenses, Per Day	\$391	\$465
Average Net Operating Income after Expenses, Per Admission	\$1,611	\$1,916

*Source: Hospital management.*

<b>Table Ten-B: Average Charges, Deductions, Net Charges, Net Operating Income TriStar Horizon Medical Center (Including NICU)</b>		
	<b>CY2017</b>	<b>CY2018</b>
Patient Days	1,105	1,300
Admissions or Discharges	85	100
Average Gross Charge Per Day	\$3,435	\$3,675
Average Gross Charge Per Admission	\$44,659	\$47,780
Average Deduction from Operating Revenue per Day	\$1,824	\$2,025
Average Deduction from Operating Revenue per Admission	\$23,718	\$26,330
Average Net Charge (Net Operating Revenue) Per Day	\$1,611	\$1,650
Average Net Charge (Net Operating Revenue) Per Admission	\$20,941	\$21,450
Average Net Operating Income after Expenses, Per Day	\$317	\$465
Average Net Operating Income after Expenses, Per Admission	\$4,118	\$6,050

*Source: Hospital management.*

**C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.**

The NICU is expected to operate with a positive margin; and its development will not impose any significant debt service. So the project will not affect any hospital charges in other departments, or for newborns in Level I status.

The response to C(II).6.B below provides the proposed average gross charges for the most frequent services in the NICU, and provides comparisons to other HCA Level II NICU's in Middle Tennessee, whose charges are available to the applicant. Charges at non-HCA hospitals in the area are not known.

**C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).**

Please see the following pages for Table Eleven, showing the applicant's most frequent charges for proposed NICU services, and comparable charges at other area hospitals to which the applicant has access.

Table Eleven: TriStar Horizon Medical Center NICU-- Frequent Charges With Area Comparables						
DRG	Descriptor	2015 Medicare Allowable	2015 Summit Medical Center NICU	20915 Stonecrest Medical Center NICU	Yr 1-2017* Horizon Medical Center Proposed NICU	Yr 2-2018* Horizon Medical Center Proposed NICU
790	Extreme immaturity or respiratory distress syndrome, neonate	\$24,861	\$65,769	\$91,869	\$85,125	\$91,084
791	Prematurity with major problems	\$16,979	\$50,243	\$65,368	\$62,430	\$66,800
792	Prematurity without major problems	\$10,245	\$13,007	\$13,504	\$14,316	\$15,318
793	Full term neonate with major problems	\$17,442	\$19,293	\$25,756	\$24,326	\$26,029
794	Neonate with other significant problems	\$6,173	\$5,069	\$6,280	\$6,128	\$6,557

Source: Hospital management.

**C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.**

The projected inpatient days in the NICU are sufficient to show a positive net operating income. The utilization assumptions are historically based in terms of admissions and lengths of stay. Cost-effectiveness is assured.

**C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.**

The proposed NICU projects a small positive net operating income in each of its first two years. Although the service is new, reimbursement relationships are already in place with NICU care insurers; so there will be no initial start-up period in which cash flow will be delayed. The consolidated hospital-wide Projected Data Chart shows that the hospital has sufficient cash flow to absorb any losses that the NICU could incur, if utilization projections are not attained.

**C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.**

As the tables below show, the hospital is very accessible to all of the above listed groups. The proposed NICU will be especially utilized by TennCare infants. Low-income newborns without insurance have almost total access to TennCare coverage and Horizon will continue to ensure their enrollments as NICU care is provided.

<b>Table Twelve-A: TriStar Horizon Medical Center, CY 2014</b>		
Payor	Percent of Gross Revenues	Amount of Gross Revenues
Medicare	62%	\$246,711,595
Medicaid/TennCare	15%	\$59,688,289
Commercial/HMO/PPO	13%	\$55,709,070
Charity/Self-Pay	8%	\$31,833,754
Other	2%	\$3,979,219
Total	100%	\$397,921,927

Source: Hospital management.

<b>Table Twelve-B: TriStar Horizon Medical Center, Year One--CY2017</b>		
Payor	Percent of Gross Revenues	Amount of Gross Revenues
Medicare	63.0%	\$332,452,260
Medicaid/TennCare	16.0%	\$84,432,320
Commercial/HMO/PPO	14.0%	\$73,878,280
Charity/Self-Pay	6.0%	\$31,662,120
Other	1.0%	\$5,277,020
Total	100.0%	\$527,702,000

Source: Hospital management.

<b>Table Twelve-C: TriStar Horizon Medical Center NICU, Year One--CY2017</b>		
Payor	Percent of Gross Revenues	Amount of Gross Revenues
Medicare	--	--
Medicaid/TennCare	80.0%	\$3,036,800
Commercial/HMO/PPO	18.0%	\$683,280
Charity/Self-Pay	2.0%	\$75,920
Other	--	--
Total	100.0%	\$3,796,000

Source: Hospital management.

**C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.**

These are provided as Attachment C, Economic Feasibility--10.

**C(II).11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:**

**A. A DISCUSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.**

**B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.**

In terms of cost, this is the hospital's best design option because it does not require new construction, and because the cost of the renovation compares favorably to hospital capital project costs monitored by the HSDA Registry. Demand data indicates that no more than six NICU beds will be utilized at times of heavy demand, because the average daily census of the NICU will average between 3 and 4 infants.

Not offering a Level II NICU is unacceptable because the long-range viability of obstetrics in this area requires the presence of a Level II program, and because rural residents in these counties deserve accessibility to Level II neonatal care that is more comparable to that of urban populations that have multiple options close by.

**C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AND/OR WORKING RELATIONSHIPS, E.G., TRANSFER AGREEMENTS, CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.**

TriStar Horizon's special relationship with TriStar Centennial Women's and Children's Hospital Level III NICU has been described elsewhere in this application. In the first 10 months of CY 2010, Horizon has transported 52 newborns to Level II programs; 98% of those transports (51 newborns) have been to Centennial Women's and Children's Hospital. Level III and IV transfers have gone to Centennial and to Vanderbilt Medical Center.

The Centennial Women's and Children's Hospital staff and neonatology group have worked closely with Horizon in planning the project. They will assist and train Horizon's Level II NICU staff on a continuing basis.

**C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.**

The projected inpatient days in the NICU are sufficient to show a positive net operating income. The utilization assumptions are historically based in terms of admissions and lengths of stay. Cost-effectiveness is assured.

**C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.**

The proposed NICU projects a small positive net operating income in each of its first two years. Although the service is new, reimbursement relationships are already in place with NICU care insurers; so there will be no initial start-up period in which cash flow will be delayed. The consolidated hospital-wide Projected Data Chart shows that the hospital has sufficient cash flow to absorb any losses that the NICU could incur, if utilization projections are not attained.

**C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.**

As the tables below show, the hospital is very accessible to all of the above listed groups. The proposed NICU will be especially utilized by TennCare infants. Low-income newborns without insurance have almost total access to TennCare coverage and Horizon will continue to ensure their enrollments as NICU care is provided.

<b>Table Twelve-A: TriStar Horizon Medical Center, CY 2014</b>		
Payor	Percent of Gross Revenues	Amount of Gross Revenues
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The Centennial Women's and Children's Hospital staff and neonatology group have worked closely with Horizon in planning the project. They will assist and train Horizon's Level II NICU staff on a continuing basis.

**Entities Receiving the Majority of Discharges from Horizon Medical Center**

Amedisys Home Care, Dickson  
Guardian Home Care of Nashville, Dickson  
Home Care Solutions, Dickson  
Home Health Care of Middle Tennessee, Dickson  
Caris Healthcare (hospice), Dickson  
Avalon Hospice, Dickson  
Dickson Healthcare Center (NH), Dickson  
NHC Healthcare (NH), Dickson  
Waverly Health Care and Rehabilitation (NH) Waverly  
Select Specialty Hospital (LTAC), Nashville  
Kindred Hospital (LTAC), Nashville

## Home Health Care Agency

### **Home Care Solutions - Dickson**

762 Highway 46 S  
Dickson, TN 37055  
Tel: (615) 441-0009  
Fax (615) 446-7206  
Covers Dickson and surrounding counties

### **Guardian Home Care Dickson**

407 Henslee Drive  
Dickson, TN 37055  
Tel: (615) 441-1747  
Fax: 615-441-3621  
Covers Dickson and surrounding counties

### **Amedisys Home Health Care - Dickson**

437 Henslee Dr  
Dickson, TN 37055  
Tel: (615) 326-0369  
Fax: (615) 326-0369  
Covers Dickson and Surrounding counties

### **NHC Home Care - Dickson**

305 Highway 70 East  
Dickson, TN 37055  
Tel: (615) 446-5574  
Fax: (615) 446-5101  
Covers Dickson and Surrounding counties.

### **SunCrest Home Health-Dickson (Does not cover Hickman County or Humphreys)**

705 Hwy 70 East Ste. 9  
Dickson, TN 37055  
Tel: (615) 446-8282  
Fax: (615) 446-2282

### **Saint Thomas Home Health**

135 EAST SWAN ST  
Centerville, TN 37033  
Tel: (931) 729-4500  
Fax: (931) 729-9000

**FRIENDSHIP HOME HEALTH -**

NASHVILLE

333 PLUS PARK BLVD

Nashville, TN 37217

Tel: (615) 365-4336

Fax: (615) 365-7897

**Volunteer Home Care of West**

Tennessee, Inc.

405 Tennessee Avenue South

P.O. Box 25

Parsons, TN 38363

Tel: (731) 847-8250

Fax: (731) 847-8255

Covers West TN.

**Tennessee Quality Homecare - Parsons**

1939 Tennessee Avenue North

P.O. Box 635

Parsons, TN 38363

Tel: (866) 846-8081

Fax: (866) 369-1053

Covers West TN.

## **Dickson County**

DICKSON HEALTHCARE CENTER  
901 NORTH CHARLOTTE ST.  
DICKSON , TN 37055  
*Attn:* BONNIE CREWS  
(615) 446-8150

NHC HEALTHCARE, DICKSON  
812 N. CHARLOTTE STREET  
DICKSON , TN 37055  
*Attn:* STEVEN YOKLEY  
(615) 446-8046

## **Houston County**

SIGNATURE HEALTHCARE OF ERIN  
278 ROCKY HOLLOW ROAD  
ERIN , TN 37061-6053  
*Attn:* BEVERLY WALL  
(931) 289-4141

## **Humphreys County**

HUMPHREYS COUNTY NURSING HOME  
670 HIGHWAY 13 SOUTH  
WAVERLY , TN 37185  
*Attn:* PHYLLIS CHERRY  
(931) 296-2532

WAVERLY HEALTH CARE AND REHABILITATION CENTER, INC.  
895 POWERS BLVD.  
WAVERLY , TN 37185  
*Attn:* RONALD E. KNOX  
(931) 296-7552

## **Hickman County**

HICKMAN COMMUNITY NURSING HOME  
135 EAST SWAN STREET  
CENTERVILLE , TN 37033  
*Attn:* JACK M. KELLER  
(931) 729-3513

LIFE CARE CENTER OF CENTERVILLE  
112 OLD DICKSON ROAD  
CENTERVILLE , TN 37033  
*Attn:* JOHN M. PUGH  
(931) 729-4236

Hospice Dickson County

CARIS HEALTHCARE  
114 HIGHWAY 70 EAST, SUITE 3  
DICKSON , TN 37055

*Attn:*

(615) 441-5296

*Certified Counties*

Bedford, Cheatham, Davidson, Dickson, Franklin, Giles, Hardin, Hickman, Houston, Humphreys, Lawrence, Lewis, Lincoln, Marshall, Maury, Montgomery, Moore, Perry, Rutherford, Stewart, Wayne, Williamson

**AVALON HOSPICE**

216 E. College St., Building D, Suite 3  
Dickson, TN 37055

P: 615-326-0135

*Certified Counties*

All Counties

**ALIVE HOSPICE**

1718 Patterson Street

Nashville, TN 37203

Phone: 615-327-1085

Toll Free: 800-327-1085

Fax: 615-321-8902

Intake: 615-963-4807

*Certified Counties*

Alive Hospice serves the following counties in Middle Tennessee: Bedford, Cannon, Cheatham, Coffee, Davidson, DeKalb, Dickson, Robertson, Rutherford, Sumner, Williamson, Wilson

**C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.**

The proposed NICU in Dickson will have very positive impacts on its rural service area. It will reduce the emotional strain of separation of a newborn from the family, reduce significant family travel times and expense of daily drives to Nashville to be with newborns, and reduce delays in neonatal care while awaiting neonatal transport. For Level II infants born at TriStar Horizon, the project will eliminate substantial charges (and some risk) of neonatal ambulance transport to and from downtown Nashville--which have only recently become necessary due to changes in pediatric clinical guidelines.

It will positively impact its affiliated Level III NICU in downtown Nashville, at TriStar Centennial Women's and Children's Hospital, by relieving it of Level II care for substantial numbers of infants from the Dickson project service area, freeing up resources for the additional census seeking care at that Level III nursery as its pediatric subspecialties expand in this and subsequent years.

The NICU should not have any significant adverse impact on other Level II facilities. First, there is no NICU in the service area that can be affected. Second, the downtown NICU programs that could be affected other than Centennial—Vanderbilt and Baptist—probably do not derive a large percent of their Level II NICU admissions from this service area. Third, TriStar Horizon projects that the great majority of its admissions will be service area infants who otherwise would be transported to TriStar Centennial Women's and Children's Hospital (which supports this project).

**C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.**

Please see the following page for a Table of projected FTE's and salary ranges.

The Department of Labor and Workforce Development website indicates the following Middle Tennessee region's annual salary information for clinical employees of this project. The Department's recently revised salary surveys appear not to include many healthcare positions that were surveyed in previous years.

<b>Table Thirteen: TDOL Surveyed Average Hourly Salaries for the Region</b>			
<b>Position</b>	<b>Entry</b>	<b>Mean</b>	<b>Experienced</b>
RN (unlisted)			
Respiratory Therapist	\$20.63	\$24.86	\$26.98
Pharmacist	\$46.78	\$57.93	\$63.51
Social Worker	\$15.36	\$25.63	\$30.02
Lactation Nurse (unlisted)			

Table Fourteen : TriStar Horizon Medical Center--Proposed Level II NICU--Incremental Staffing Needed CY2016 - CY2017							
Position Type (RN, etc.)	Current 2015	Year 1 FTE's	Year 2 FTE's	Each Position		Total Potential Salaries, Yr Two	
				Minimum Salary	Maximum Salary	Minimum	Maximum
RN (Ratio 1:2 for NICU)	0	9.0	9.0	22.00	32.49	523,036.80	772,430.26
RT (Ratio 1:6 for NICU)	0	2.2	2.2	20.63	29.91	119,891.66	173,822.56
Pharmacist	0	0.4	0.4	49.50	64.35	52,303.68	67,994.78
Social Services	0	0.4	0.4	17.41	24.37	18,396.10	25,750.32
Lactation Consultant	0	0.4	0.4	23.98	35.97	25,338.23	38,007.34
<b>Totals</b>	<b>0</b>	<b>12.4</b>	<b>12.4</b>			<b>738,966.47</b>	<b>1,078,005.26</b>

Source: Hospital Management

Notes:

RT - Adding a 12 hr shift on nights to cover the NICU. There is enough staff on days to cover the unit.

Pharmacist - Adding more hours to the pharmacy dept to cover NICU.

Social Services - Hospital has two social workers. Some of employee's hrs allocated to NICU.

Lactation Consultant - Hospital has a full time lactation consultant. Some of employee's hrs allocated to NICU.  
Includes benefit cost at 27%.

**C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.**

TriStar Horizon Medical Center has decades of successful experience with staffing its medical-surgical services and maintaining compliance with State requirements and standards. This project can be staffed without delay. Most of the staffing increase will be additional hours allocated to NICU care for personnel already employed in the hospital or in the Level I nursery program.

The applicant's parent company, HCA, and its local Division office and hospitals, also have many years of successful experience in this regard with respect to staffing Neonatal Intensive Care services appropriately. The Division's Level III NICU in Nashville will continue to assist TriStar Horizon Medical Center in developing this project, and in educating and training its staff to operate a Level II NICU in compliance with the Tennessee Perinatal Guidelines, State licensing standards, and accreditation requirements.

**C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW POLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.**

The applicant so verifies.

**C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).**

Horizon Medical Center is a clinical rotation site for numerous students in health professions training programs. These include Nursing/Nurse Practitioner, Occupational Therapy, Physical Therapy, Respiratory Therapy, Pharmacy, CRNA, and Paramedic training programs. Horizon's affiliates for these clinical rotations include Aquinas College, Austin Peay State University, Belmont University, Bethel College, Columbia State Community College, East Tennessee State University, Middle Tennessee School of Anesthesia, Lipscomb University, Mercer University, Murray State University, Tennessee State University, Tennessee Technology Center, Union University, the University of Tennessee in Memphis and in Martin, Vanderbilt University, and Volunteer State Community College.

**C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.**

The applicant so verifies.

**C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION**

**LICENSURE:** Board for Licensure of Healthcare Facilities  
Tennessee Department of Health

**CERTIFICATION:** Medicare Certification from CMS  
TennCare Certification from TDH

**ACCREDITATION:** Joint Commission

**C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.**

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

**C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.**

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C).

**C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.**

None.

**C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.**

None.

**C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.**

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

## **PROOF OF PUBLICATION**

Attached.

## **DEVELOPMENT SCHEDULE**

**1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.**

The Project Completion Forecast Chart is provided after this page.

**2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.**

Not applicable. The applicant anticipates completing the project within the period of validity.

## PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

January 27, 2016

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	4	2/16
2. Construction documents approved by TDH	64	4/16
3. Construction contract signed	79	4/16
4. Building permit secured	94	4/16
5. Site preparation completed	n/a	n/a
6. Building construction commenced	95	5/16
7. Construction 40% complete	185	8/16
8. Construction 80% complete	215	9/16
9. Construction 100% complete	260	10/16
10. * Issuance of license	n/a	n/a
11. *Initiation of service	320	12/16
12. Final architectural certification of payment	380	2/17
13. Final Project Report Form (HF0055)	425	4/17

**\* For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

**Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**



## INDEX OF ATTACHMENTS

A.4	Ownership--Legal Entity and Organization Chart (if applicable)
A.6	Site Control
B.III.	Plot Plan
B.IV.	Floor Plan
C, Need--1.A	Documentation of Project-Specific Criteria
C, Need--1.A.3.	Qualifications
C, Need--3	Service Area Maps
C, Economic Feasibility--1	Documentation of Construction Cost Estimate
C, Economic Feasibility--2	Documentation of Availability of Funding
C, Economic Feasibility--10	Financial Statements
C, Orderly Development--7(C)	Licensing & Accreditation Inspections
Miscellaneous Information	JAMA Article--Effects of Low Blood Sugar on Neonates Quickfacts Demographic Data on Service Area TennCare Enrollments in Service Area
Support Letters	

**A.4--Ownership**  
**Legal Entity and Organization Chart**

# Board for Licensing Health Care Facilities



State of Tennessee

## DEPARTMENT OF HEALTH

00000000029

No. of Beds 0157

*This is to certify, that a license is hereby granted by the State Department of Health to*

*to conduct and maintain a*

CENTRAL TENNESSEE HOSPITAL CORPORATION

Hospital

TRISTAR HORIZON MEDICAL CENTER

Located at

111 HIGHWAY 70 EAST, DICKSON

County of

DICKSON

, Tennessee.

*This license shall expire* MAY 12, 2016, *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

*In Witness Whereof, we have hereunto set our hand and seal of the State this* 21ST *day of* APRIL, 2015.

GENERAL HOSPITAL  
PEDIATRIC BASIC HOSPITAL

*In the Distinct Category(ies) of:*



*By* Theresa J. Davis, MPH  
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

*By* Mark J. Dwyer  
COMMISSIONER

# Horizon Medical Center

Dickson, TN

has been Accredited by



## The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the  
Hospital Accreditation Program

June 1, 2013

Accreditation is customarily valid for up to 36 months.

*Rebecca J. Patchin, MD*

Rebecca J. Patchin, M.D.  
Chair, Board of Commissioners

Organization ID #7826  
Print/Reprint Date: 10/21/13

*Mark R. Chassin, MD*

Mark R. Chassin, MD, FACP, MPP, MPH  
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at [www.jointcommission.org](http://www.jointcommission.org).





Business Services Online > Find and Update a Business Record

## Business Information Search

As of October 13, 2015 we have processed all corporate filings received in our office through October 12, 2015 and all annual reports received in our office through October 12, 2015.

Click on the underlined control number of the entity in the search results list to proceed to the detail page. From the detail page you can verify the entity displayed is correct (review addresses and business details) and select from the available entity actions - file an annual report, obtain a certificate of existence, file an amendment, etc.

Search: 1-1 of 1

Search Name:  ☒ Starts With ☐ Contains

Control #:

Active Entities Only: ☐

Control #	Entity Type	Name	Name Type	Name Status	Entity Filing Date	Entity Status
<u>000294588</u>	CORP	CENTRAL TENNESSEE HOSPITAL CORPORATION TENNESSEE	Entity	Active	05/10/1995	Active

1-1 of 1

Information about individual business entities can be queried, viewed and printed using this search tool for free.

If you want to get an electronic file of all business entities in the database, the full database can be downloaded for a fee by [Clicking Here](#).

[Click Here](#) for information on the Business Services Online Search logic.

Division of Business Services  
312 Rosa L. Parks Avenue, Snodgrass Tower, 6th  
Floor  
Nashville, TN 37243  
615-741-2286

[Email](#) | [Directions](#) | [Hours and Holidays](#) | [Methods of Payment](#)

Business Filings and Information (615) 741-2286 | [TNSOS.CORPINFO@tn.gov](mailto:TNSOS.CORPINFO@tn.gov)  
Certified Copies and Certificate of Existence (615) 741-6488 | [TNSOS.CERT@tn.gov](mailto:TNSOS.CERT@tn.gov)  
Motor Vehicle Temporary Liens (615) 741-0529 | [TNSOS.MVTL@tn.gov](mailto:TNSOS.MVTL@tn.gov)  
Uniform Commercial Code (UCC) (615) 741-3276 | [TNSOS.UCC@tn.gov](mailto:TNSOS.UCC@tn.gov)  
Workers' Compensation Exemption Registrations (615) 741-0526 | [TNSOS.WCER@tn.gov](mailto:TNSOS.WCER@tn.gov)  
Apostilles & Authentications (615) 741-0536 | [TNSOS.ATS@tn.gov](mailto:TNSOS.ATS@tn.gov)  
Summons (615) 741-1799 | [TNSOS.ATS@tn.gov](mailto:TNSOS.ATS@tn.gov)  
Trademarks (615) 741-0531 | [TNSOS.ATS@tn.gov](mailto:TNSOS.ATS@tn.gov)

### OUR MISSION

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### LINKS

Tennessee General Assembly  
Bureau of Ethics and Campaign Finance  
Tennessee Code Unannotated  
NASS  
State Comptroller  
State Treasurer

**Secretary of State****Corporations Section**

mes K. Polk Building, Suite 1800

Nashville, Tennessee 37243-0306

DATE: 05/10/95  
REQUEST NUMBER: 3009-2535  
TELEPHONE CONTACT: (615) 741-0537  
FILE DATE/TIME: 05/10/95 1607  
EFFECTIVE DATE/TIME: 05/10/95 1607  
CONTROL NUMBER: 0294588

TO:  
WALLER LANSDEN DORTCH & DAVIS  
511 UNION ST S2100

NASHVILLE, TN 37219-1760

RE:  
CENTRAL TENNESSEE HOSPITAL CORPORATION  
CHARTER - FOR PROFIT

CONGRATULATIONS UPON THE INCORPORATION OF THE ABOVE ENTITY IN THE STATE OF TENNESSEE, WHICH IS EFFECTIVE AS INDICATED.

A CORPORATION ANNUAL REPORT MUST BE FILED WITH THE SECRETARY OF STATE ON OR BEFORE THE FIRST DAY OF THE FOURTH MONTH FOLLOWING THE CLOSE OF THE CORPORATION'S FISCAL YEAR. ONCE THE FISCAL YEAR HAS BEEN ESTABLISHED, PLEASE PROVIDE THIS OFFICE WITH THE WRITTEN NOTIFICATION. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE CORPORATION AT THE ADDRESS OF ITS PRINCIPAL OFFICE OR TO A MAILING ADDRESS PROVIDED TO THIS OFFICE IN WRITING. FAILURE TO FILE THIS REPORT OR TO MAINTAIN A REGISTERED AGENT AND OFFICE WILL SUBJECT THE CORPORATION TO ADMINISTRATIVE DISSOLUTION.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE. PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

**STATE OF TENNESSEE, DICKSON COUNTY**

The foregoing instrument and certificate were noted  
Note Book 128 Page 128 at 9:00 o'clock A.M. 5-24-95  
and recorded in Vol. 392 Page 226 State Tax Paid \$  
Fee \_\_\_\_\_ Recording Fee 5.00 Total \$ 5.00  
Witness My Hand  
Receipt No. 5696

  
Register

FOR: CHARTER - FOR PROFIT

FROM:  
WALLER LANSDEN ETC (511 UNION/NASHVILLE)  
SUITE 2100  
511 UNION STREET  
NASHVILLE, TN 37219-1760



RILEY C. DARNELL  
SECRETARY OF STATE

**Secretary of State****Division of Business Services****312 Eighth Avenue North****6th Floor, William R. Snodgrass Tower****Nashville, Tennessee 37243**

ISSUANCE DATE: 05/03/2002

REQUEST NUMBER: 02123505

TELEPHONE CONTACT: (615) 741-6488

CHARTER/QUALIFICATION DATE: 05/10/1995

STATUS: ACTIVE

CORPORATE EXPIRATION DATE: PERPETUAL

CONTROL NUMBER: 0294588

JURISDICTION: TENNESSEE

TO:  
CFS  
8161 HWY 100

NASHVILLE, TN 37221

REQUESTED BY:

CFS  
8161 HWY 100

NASHVILLE, TN 37221

**CERTIFICATE OF EXISTENCE**

I, RILEY C DARNELL, SECRETARY OF STATE OF THE STATE OF TENNESSEE DO HEREBY CERTIFY THAT

**"CENTRAL TENNESSEE HOSPITAL CORPORATION"**

IS A CORPORATION DULY INCORPORATED UNDER THE LAW OF THIS STATE WITH DATE OF  
INCORPORATION AND DURATION AS GIVEN ABOVE;  
THAT ALL FEES, TAXES, AND PENALTIES OWED TO THIS STATE WHICH AFFECT THE  
EXISTENCE OF THE CORPORATION HAVE BEEN PAID;  
THAT THE MOST RECENT CORPORATION ANNUAL REPORT REQUIRED HAS BEEN FILED  
WITH THIS OFFICE; AND  
THAT ARTICLES OF DISSOLUTION HAVE NOT BEEN FILED; AND  
THAT ARTICLES OF TERMINATION OF CORPORATE EXISTENCE HAVE NOT BEEN FILED

FOR: REQUEST FOR CERTIFICATE

ON DATE: 05/03/02

FROM:  
CFS  
8161 HIGHWAY 100  
#372  
NASHVILLE, TN 37221-0000

	FEES	
RECEIVED:	\$120.00	\$0.00
TOTAL PAYMENT RECEIVED:	\$120.00	

RECEIPT NUMBER: 00003079882  
ACCOUNT NUMBER: 00101230*Riley C Darnell*RILEY C. DARNELL  
SECRETARY OF STATE

## CHARTER

## OF


## CENTRAL TENNESSEE HOSPITAL CORPORATION

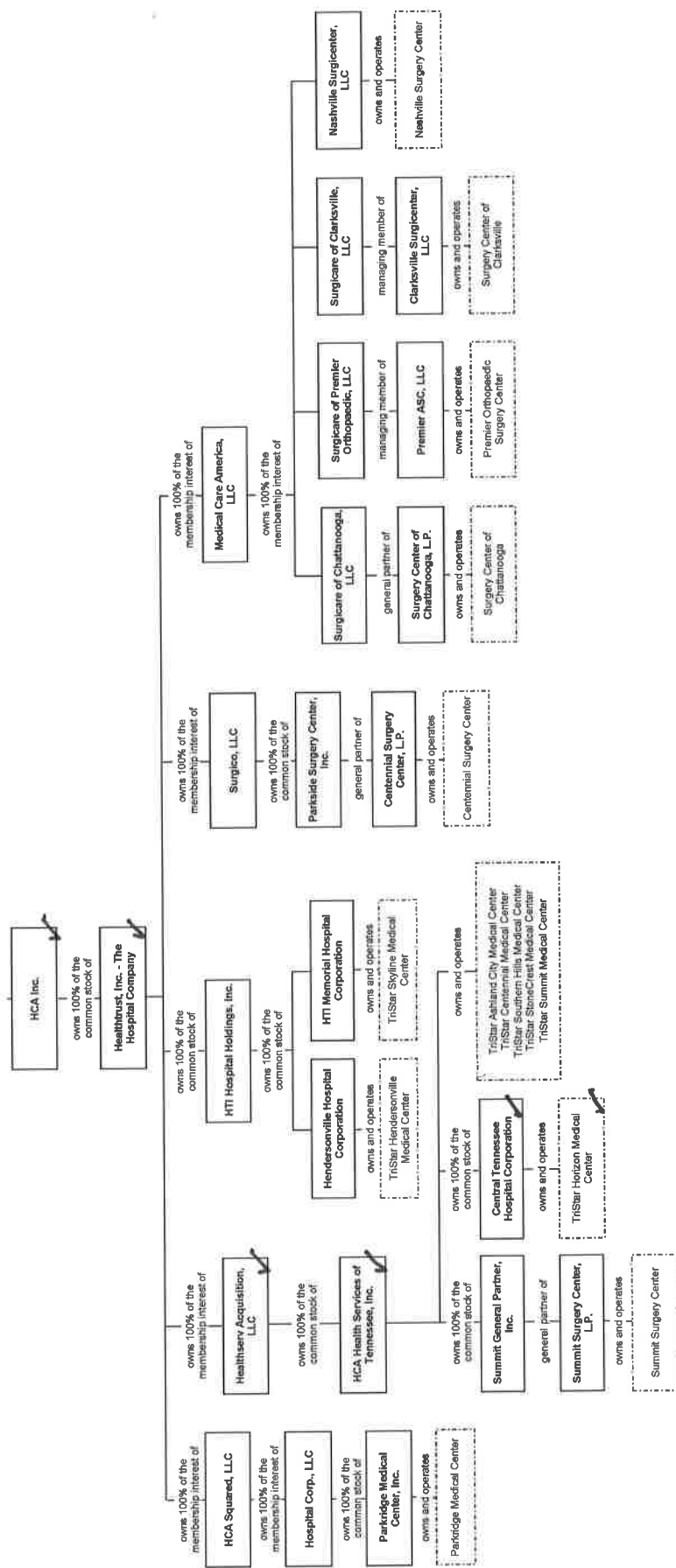
The undersigned person, under the Tennessee Business Corporation Act, adopts the following Charter for the above listed corporation:

1. The name of the corporation is Central Tennessee Hospital Corporation
2. The number of shares of stock the corporation is authorized to issue is one thousand (1,000) shares of common stock, par value of \$1.00 per share.
3. (a) The complete address of the corporation's initial registered office in Tennessee is 500 Tallan Building, Two Union Square, Chattanooga, Hamilton County, Tennessee 37402.  
(b) The name of the initial registered agent, to be located at the address listed in 3(a), is The Prentice Hall Corporation System, Inc.
4. The name and complete address of each incorporator is:  
  
Douglas S. Jackson, Esq.  
117 Highway 70 East  
Dickson, Tennessee 37055
5. The complete address of the corporation's initial principal office is 111 Highway 70 East, Dickson, Dickson County, Tennessee 37055.
6. The corporation is for profit.
7. The persons serving on the initial Board of Directors for the corporation are:

James T. Jackson	111 Highway 70 East	Dickson, TN 37055
James W. Jackson	111 Highway 70 East	Dickson, TN 37055
Anne Deason	111 Highway 70 East	Dickson, TN 37055
Bob Spencer	111 Highway 70 East	Dickson, TN 37055
Bill Kruse	111 Highway 70 East	Dickson, TN 37055
Mike Legg	111 Highway 70 East	Dickson, TN 37055

Dated: May 2, 1995.

  
Doug Jackson



**HCA FACILITIES IN TENNESSEE  
2015**

**HOSPITALS AND HOSPITAL AFFILIATES**

TriStar Ashland City Medical Center  
313 North Main Street  
Ashland City, TN 37015  
615-792-3030

TriStar Centennial Medical Center  
2300 Patterson Street  
Nashville, TN 37203  
615-342-1040

Parthenon Pavilion  
2401 Parman Place

Sarah Cannon Cancer Center  
250 25<sup>th</sup> Ave. North

Sarah Cannon Research Institute  
3522 West End Avenue

The Children's Hospital at TriStar Centennial Medical Center  
222 Murphy Avenue

TriStar Centennial Emergency Room at Spring Hill  
3001 Reserve Blvd.  
Spring Hill, TN 37174

TriStar Hendersonville Medical Center  
355 New Shackle Island Road  
Hendersonville, TN 37075  
615-338-1102

TriStar Portland Emergency Room  
105 Redbud Drive  
Portland, TN 37148

TriStar Horizon Medical Center  
111 Highway 70 East  
Dickson, TN 37055  
615-441-2357

Natchez Imaging  
101 Natchez Park Drive

Radiation Oncology @ SCCC  
105 Natchez Park Drive

Tennessee Oncology@ SCCC  
103 Natchez Park Drive

TriStar Parkridge Medical Center  
2333 McCallie Avenue  
Chattanooga, TN 37404  
423-493-1772

TriStar Parkridge East Hospital  
941 Spring Creek Road  
Chattanooga, TN 37412  
423-855-3500

TriStar Parkridge West Medical Center  
1000 Tn Highway 28  
Jasper, TN 37247

TriStar Parkridge Valley Hospital  
200 Morris Hill Road  
Chattanooga, TN 37421  
423-499-1204

TriStar Skyline Medical Center  
3441 Dickerson Pike  
Nashville, TN 37207  
615-769-7114

TriStar Skyline Madison Campus  
500 Hospital Drive  
Madison, TN 37115  
615-860-6301

TriStar Southern Hills Medical Center  
391 Wallace Road  
Nashville, TN 37211  
615-781-4000

TriStar StoneCrest Medical Center  
200 StoneCrest Blvd.  
Smyrna, TN 37167  
615-768-2508

TriStar Summit Surgery Center  
3901 Central Pike  
Suite 152  
Hermitage, TN 37076  
615-391-7200

#### **OTHER FACILITIES**

Centennial Surgery Center  
345 23rd Avenue North, Suite 201  
Nashville, TN 37203  
615-327-1123

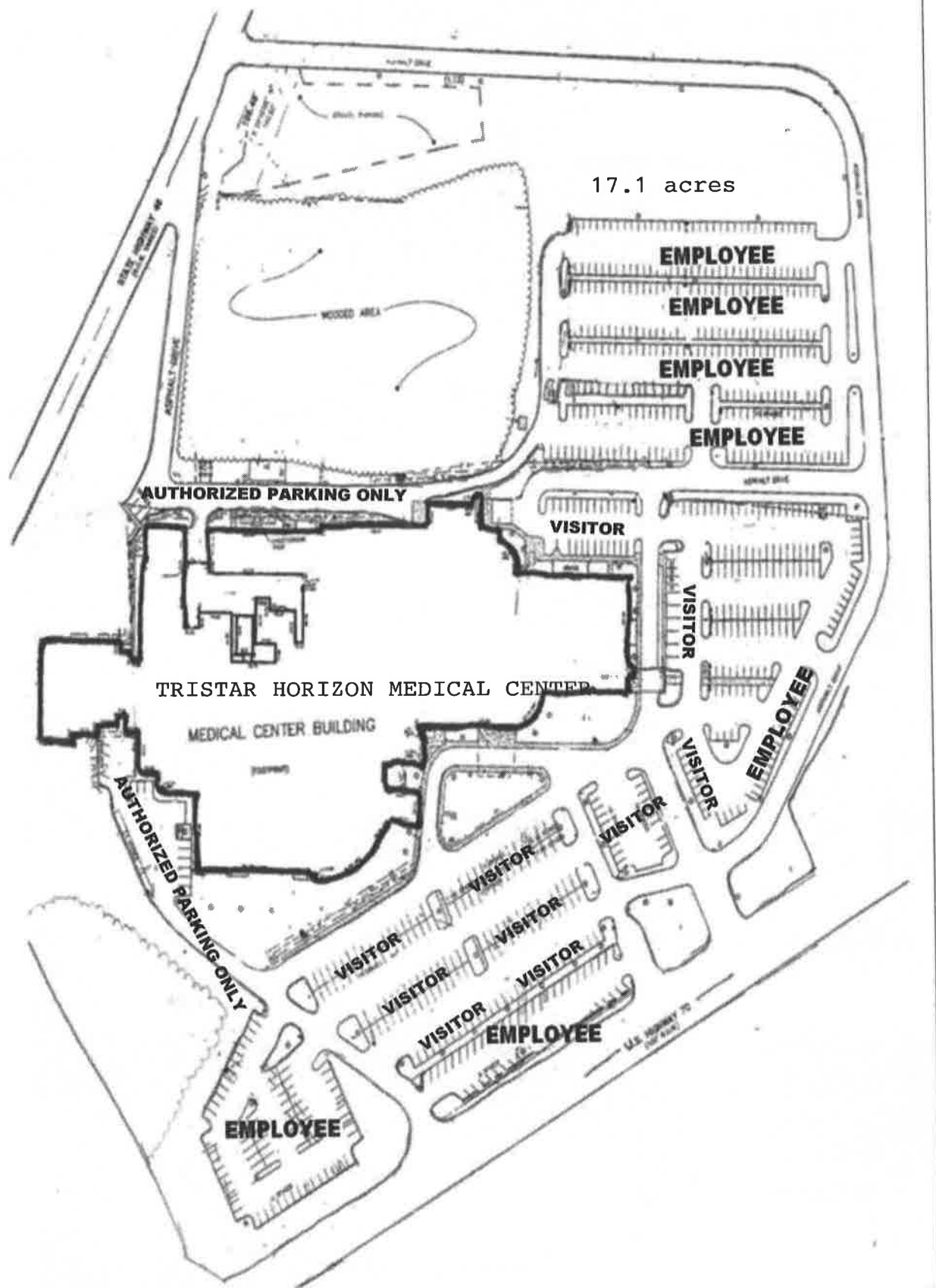
Premier Orthopedics Surgery Center  
394 Harding Place  
Suite 100  
Nashville, TN 37211  
615-332-3600

TriStar Summit Medical Center  
5655 Frist Blvd.  
Hermitage, TN 37076  
615-316-4902

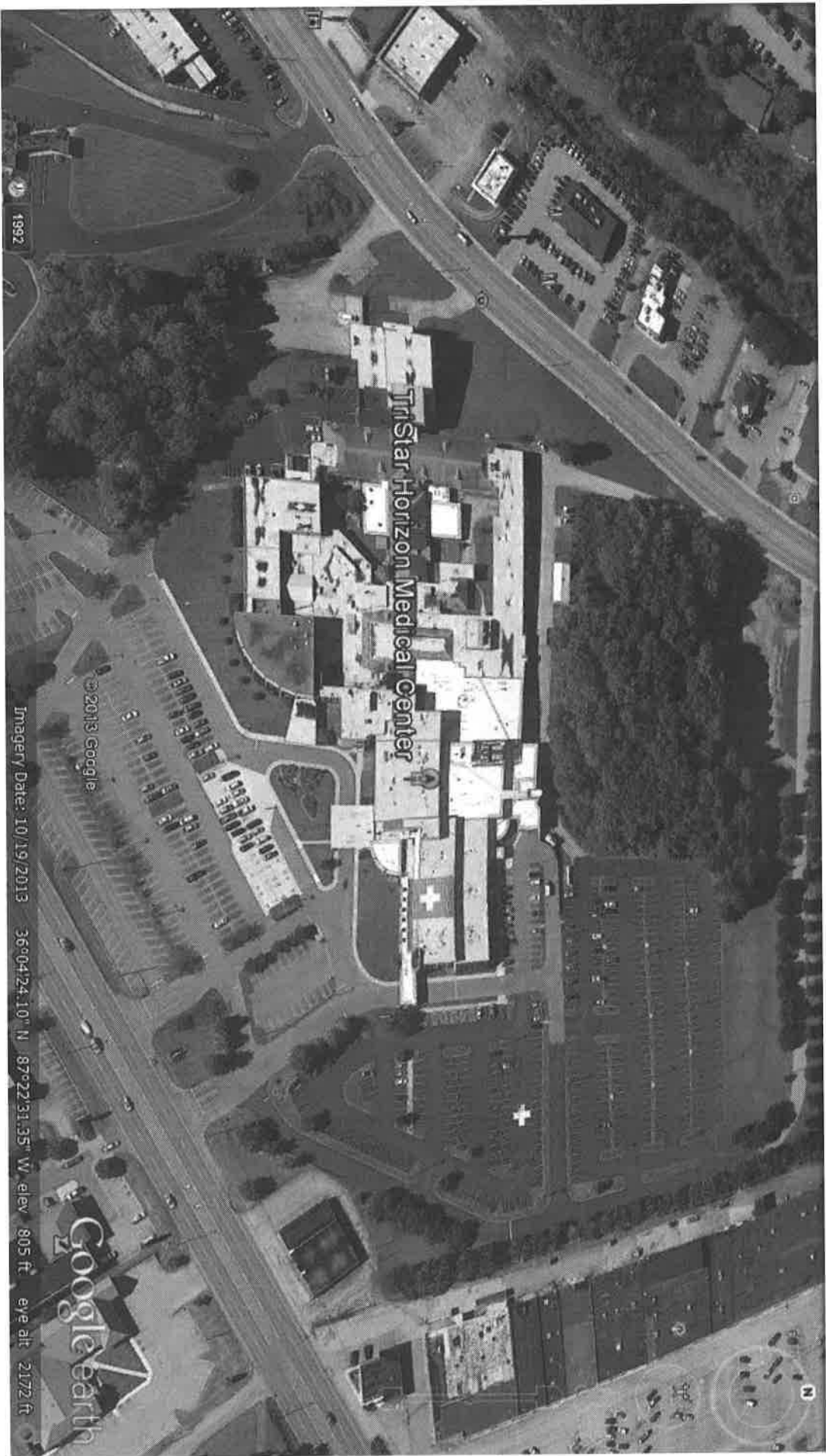
Surgery Center of Chattanooga  
400 North Holtzclaw Avenue  
Chattanooga, TN 37404  
423-698-6871

## **A.6--Site Control**

### **B.III.--Plot Plan**



17.1 acres



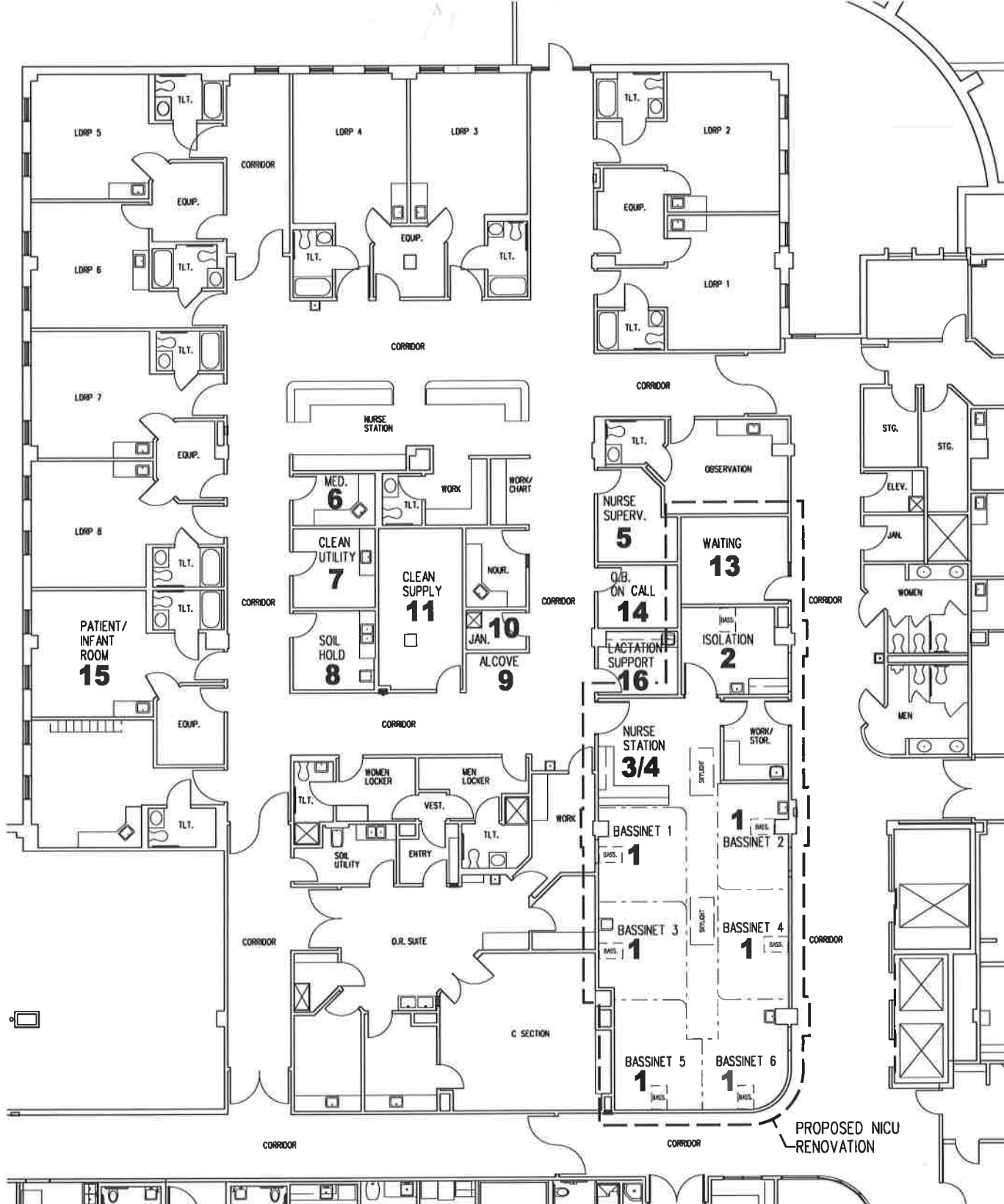
TriStar Horizon Medical Center

©2013 Google

Imagery Date: 10/19/2013 36°04'24.10" N 87°22'31.35" W elev 805 ft eye alt 2172 ft

Google Earth

## **B.IV.--Floor Plan**



#### REQUIRED SPACES:

- |                                 |                               |
|---------------------------------|-------------------------------|
| 1. INFANT CUBICLE               | 9. EMERGENCY EQUIP. STG.      |
| 2. AIRBORNE INFECTION ISOL. RM. | 10. ENVIRONMENTAL SERVICE RM. |
| 3. NURSE STATION                | 11. EQUIPMENT STORAGE         |
| 4. CHART AREA                   | 12. STAFF LOCKER/TLT          |
| 5. NURSE SUPV. OFFICE           | 13. VISITOR WAITING           |
| 6. MED. STATION                 | 14. PHYSICIAN SLEEP           |
| 7. CLEAN WORK                   | 15. PATIENT/INFANT ROOM       |
| 8. SOIL HOLD                    | 16. LACTATION SUPPORT         |

Nursery Intensive Care Unit  
**TriStar  Horizon**  
**MEDICAL CENTER**  
 Dickson, Tennessee

**C, Need--1.A**  
**Documentation of Project-Specific Criteria**

## FACILITY TRANSFER AGREEMENT (Revised 04-2011)

This Transfer Agreement (the "Agreement") is made as of this 1st day of June, 2011, by and between:  
HCA Health Services of Tennessee, Inc., doing business as  
Centennial Medical Center and  
Horizon Medical Center

each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

### WITNESSETH:

**WHEREAS**, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities;  
and,

**WHEREAS**, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

**NOW, THEREFORE**, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

- (A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;
- (B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;
- (C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;
- (D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;
- (E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;
- (F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;
- (G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;
- (H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed

consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

- (I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;
- (J) Notify the Receiving Facility of the estimated time of arrival of the patient;
- (K) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer;
- (L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;
- (M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;
- (N) Recognize the right of a patient to refuse consent to treatment or transfer;
- (O) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;
- (P) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,
- (Q) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

- (A) Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within sixty (60) minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor;
- (B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred and maintain a call roster of physicians at the Receiving Facility;
- (C) Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;
- (D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;
- (E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;
- (F) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;
- (G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;
- (H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

- (I) Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of this Agreement;
- (J) Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;
- (K) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;
- (L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;
- (M) Complete, execute, and return the memorandum of transfer form to the Transferring Facility; and,
- (N) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. **Billing.** All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. *In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made at 80 % of charges or in accordance with the payment fee schedule, labeled as Exhibit --, attached hereto and incorporated herein by this reference.* In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. **Transfer Back; Discharge; Policies.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility. Such transfers shall be conducted in accordance with HCA Healthcare Corporation Ethics and Compliance Policies and Procedures (e.g., *Discharge Planning and Referrals of Patients to Post Discharge Providers Policy, LL.HH.016 and EMTALA - Transfer Policy, EM.003*).

6. **Compliance with Law.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **Indemnification; Insurance.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **Term; Termination.** The term of this Agreement shall be a minimum of one (1) year, commencing on the 1st day of June, 2011, and ending on the 31st day of May, 2016, unless sooner terminated as provided herein. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. In addition, this Agreement may be terminated immediately upon the occurrence of any of the following events:

- (A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

- (B) Either facility loses its license, or Medicare certification.

This Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **Arbitration.** Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in Nashville, Tennessee, Davidson County, in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Services and applying the laws of the state specified in section 11 below. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated provided hereunder.

10. **Entire Agreement; Modification.** This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

11. **Governing Law.** This Agreement shall be construed in accordance with the laws of the State of Tennessee in which the facility affiliated with HCA is located.

12. **Partial Invalidity.** If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

13. **Notices.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to: Centennial Medical Center  
2300 Patterson Street  
Nashville, TN 37203

Attention: Chief Executive Officer

Copy to: One Park Plaza, P.O. Box 550  
Nashville, Tennessee 37202-0550  
Attention: Kelly Duggan, Esq., Operations Counsel

If to: Horizon Medical Center  
111 Highway 70 East  
Dickson, TN 37055

Attention: Chief Executive Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

14. **Waiver.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

15. **Assignment; Binding Effect.** Each facility shall not assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

16. **Change in Law.** Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within thirty (30) days after said notice was given, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given.

*Gail England*

TENNESSEE EMERGENCY MEDICAL SERVICES FOR CHILDREN  
INTERFACILITY PEDIATRIC TRANSFER AGREEMENT  
BETWEEN  
VANDERBILT UNIVERSITY  
AND  
HORIZON MEDICAL CENTER

In consideration of the needs of the patients of the area served by both the institutions herein named, this Agreement is entered into by and between Vanderbilt University, a Tennessee not-for-profit corporation acting by and through its Vanderbilt Children's Hospital (hereinafter referred to as "VANDERBILT"), and Horizon Medical Center, Dickson, Tennessee, (hereinafter referred to as "FACILITY").

WITNESSETH:

WHEREAS, VANDERBILT is a Comprehensive Regional Pediatric Center (CRPC) serving residents of the area served by VANDERBILT and FACILITY; and

WHEREAS, FACILITY may require the services of VANDERBILT for health care needs of critically ill and/or injured pediatric patients served by FACILITY;

NOW, THEREFORE, in consideration of the promises herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

**I. TERMS AND CONDITIONS:**

- A. VANDERBILT will provide treatment and hospitalization, when possible, for critically ill and/or injured pediatric patients of FACILITY on an as-needed basis when requested by FACILITY.
- B. FACILITY will transfer pediatric patients only when the patients need specialized treatment, care or tests that are not available at FACILITY, but is available at VANDERBILT.
- C. A pediatric patient may only be transferred to VANDERBILT after a VANDERBILT attending physician accepts the patient's transfer after speaking with a FACILITY physician. If VANDERBILT's attending physician has approved and agreed to the transfer of the pediatric patient after concluding that all conditions of eligibility are met and subject to availability of appropriate personnel, space and facilities at VANDERBILT; VANDERBILT agrees to facilitate prompt admission of the pediatric patient. The parties hereto agree to conduct any patient transfers in compliance with state and federal law, including 42 U.S.C. 1395dd et seq. and any amendments thereto ("EMTALA regulations"), and such other requirements as may be imposed by the Secretary of Health and Human Services and state law.
- D. FACILITY shall provide or arrange transportation for a pediatric patient for the purpose of his or her transfer from one institution to the other under this Agreement.
- E. FACILITY has the responsibility for obtaining consent for transfer from the parents or legal guardian.

- F. The appropriate method of transportation is dependent upon pediatric patient's condition and such transportation (ground, fixed wing or rotary wing) will be determined after consultation between the transferring and receiving physicians.
- G. If the admitting physician or transferring physician should deem it medically necessary for the pediatric patient to be accompanied by personnel and/or equipment during the transfer, FACILITY shall provide or arrange for the appropriate personnel and/or equipment for the transfer.
- H. VANDERBILT and the FACILITY agree to send with each pediatric patient, at the time of transfer or, in case of emergency, as promptly as possible after the transfer, pertinent medical and other information necessary to continue the pediatric patient's treatment without interruption, together with essential identifying and administrative information.
- I. VANDERBILT shall assume responsibility for patient care at the time it takes physical custody of the pediatric patient, and shall remain responsible for patient care only during the time that VANDERBILT has such physical custody of the pediatric patient.

## **II. BILLING AND PAYMENT**

- A. It is agreed that the services rendered by VANDERBILT or the VANDERBILT physicians shall be charged to the patient, the patient's Managed Care Organization ("MCO"), or other third party payor. FACILITY shall not be held responsible for payment of services rendered to a patient by VANDERBILT or the VANDERBILT physicians and VANDERBILT and the VANDERBILT physicians shall not be held responsible for payment of services rendered to a patient by FACILITY.
- B. After the pediatric patient is accepted by VANDERBILT, FACILITY will provide VANDERBILT with all financial information necessary to enable VANDERBILT to bill patient, MCO, or other third party payor, prior to patient's transfer from FACILITY TO VANDERBILT.
- C. After the pediatric patient is accepted by VANDERBILT, FACILITY will assist VANDERBILT in obtaining any necessary authorizations or pre-certifications from the pediatric patient's MCO or other third party payor.

## **III. TERM AND TERMINATION**

- A. This Agreement shall be effective from July 25, 2000 and continue until amended, modified, or terminated. This Agreement shall be reviewed on a periodic basis and at that time, both parties will evaluate the program and policies, discuss any related problems, and make necessary revisions. Neither party shall be bound by this Agreement until it is signed by the appropriate officials as indicated on the signature page of this Agreement.
- B. Notwithstanding any other terms and conditions hereunder, this Agreement may be terminated without cause by either party by written notification to the other party at least sixty (60) days prior to the desired effective date of termination.
- C. In the event that either party shall become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceedings under the Federal Bankruptcy Act or any

other statute of any state relating to insolvency or the protection of rights of creditors, then, at the option of either party, this Agreement may be terminated immediately by either party and be of no further force and effect.

- D. In the event that either party sells all or substantially all of its assets, there is a sale of a majority ownership of either party, or there occurs a material change in the management or ownership of either party, this Agreement may be terminated by either party and be of no further force and effect.
- E. The parties warrant they are duly licensed under the laws of its state and agree to abide by applicable state and/or federal laws and regulations governing the licensure and operation of its facility. The parties further agree to give prompt notice in writing to the other party in the event of institution of proceedings for suspension or revocation of its license, and to notify the other party in the event of any suspension or revocation of its license within twenty-four (24) hours of its occurrence. This Agreement will immediately terminate upon the revocation or suspension of licensure of either party. Further, either party, at their sole discretion, may terminate this Agreement in the event the other party is given notice of the institution of proceedings to suspend or revoke its licensure.

#### **IV. INDEMNIFICATION**

Each party shall indemnify and hold harmless the other party, its trustees, officers, agents and employees, from any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceeding to the extent arising out of its own negligent acts or omissions in the performance of this Agreement. Indemnitor's obligations as set forth in the preceding sentence are conditioned upon (i) Indemnitee promptly notifying Indemnitor of any claim, demand or action, or any incident of which Indemnitee has actual or constructive knowledge, which may reasonably result in a claim, demand or action, and for which Indemnitee will look to Indemnitor for indemnification under this Section, (ii) Indemnitee, its directors, officers, agents, and employees, cooperating fully with Indemnitor in Indemnitor's investigation and review of any such claim, action or incident, and (iii) Indemnitee not entering into any admissions, agreements or settlements which may affect the rights of Indemnitee or Indemnitor without the prior written consent and approval of Indemnitor. Indemnitor reserves the right, in its sole discretion, to assume the defense of Indemnitee in any such claim, action or proceeding.

#### **V. INSURANCE**

- A. Each party shall procure and maintain for the term of this Agreement comprehensive general liability insurance, including broad form contractual, in a minimum amount of \$1,000,000/\$3,000,000. Such coverage shall act as primary insurance and no coverage of the other party shall be called upon to contribute to a loss.
- B. Each party shall procure and maintain for the term of this Agreement professional liability insurance, in a minimum amount of \$1,000,000/\$3,000,000 in coverage for all of its personnel who may participate in this Agreement. Such coverage shall be for a minimum of five (5) years following expiration or termination of this Agreement and shall provide for a retroactive date no later than the inception date of this Agreement.
- C. Each party shall procure and maintain during the term of this Agreement, workers' compensation and employer liability insurance or a self-insurance program covering all of its employees who are engaged in any work under this Agreement.

- D. The parties shall provide each other with Certificates of Insurance evidencing the above coverage.
- E. It is agreed that Vanderbilt may chose to provide the coverage stated above through a Program of self-insurance.

## VI. CONFIDENTIALITY

The parties agree to keep confidential from third parties all information which relates to or identifies a particular patient, including but not limited to the name, address, medical treatment or condition, financial status, or any other personal information which is deemed to be confidential in accordance with applicable state and federal law and standards of professional ethics and will so notify its employees, contractors, subcontractors, agents, and representatives of such agreement.

## VII. NOTIFICATION OF CLAIMS

The parties agree to notify each other as soon as possible in writing of any incident, occurrence, or claim arising out of or in connection with this Agreement which could result in a liability or claim of liability to the other party. Further, the notified party shall have the right to investigate said incident or occurrence and the notifying party will cooperate fully in this investigation.

## VIII. NOTICES

All notices or other communication provided for in this Agreement shall be given to the parties addressed as follows:

FACILITY: ~~Dr. Smith, M.D.~~ **BENJAMIN J. EVERETT**  
 Horizon Medical Center  
 111 Hwy. 70 East  
 Dickson, TN 37055  
**CHIEF EXECUTIVE OFFICER**

VANDERBILT: Terrell Smith  
 Administrative Director, Vanderbilt Children's Hospital  
 1211 27<sup>th</sup> Avenue South  
 6111 VUH  
 Nashville, TN 37232-7000

with a copy to: Contracts Administration  
 Medical Center Office  
 Vanderbilt University  
 605 Oxford House  
 1313 21st Avenue South  
 Nashville, TN 37232-4205

*L Gail England*

## IX. MEDIA

The parties agree they will not use each other party's name or programs in any advertising, promotional material, press release, publication, public announcement, or through other media, written or oral, whether to the press, to holders of publicly owned stock without the prior written consent of the party whose name is to be used.

**X. MEDICAL RECORDS**

All medical records and case histories of patients treated by VANDERBILT shall be kept at VANDERBILT, and shall be the property of VANDERBILT. FACILITY will be provided access to such medical records only with prior written consent of the patient and subject to VANDERBILT policies.

**XI. DISCRIMINATION**

In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967 and the Americans with Disabilities Act of 1990, each party hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of its policies, including admissions policies, employment, programs or activities.

**XII. ASSIGNMENT AND BINDING EFFECT**

Neither party shall assign, subcontract, or transfer any of its rights or obligations under this Agreement to a third party without the prior written consent of the other party. If an assignment, subcontract, or transfer of rights does occur in accordance with this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns.

**XIII. INDEPENDENT CONTRACTOR**

Each party shall be considered to be an independent party and shall not be construed to be an agent or representative of the other party, and therefore, has no liability for the acts or omissions of the other party. In addition, neither party, nor any of its employees, agents, or subcontractors, shall be deemed to be employees or agents of the other party. Therefore, neither party nor any of its employees, agents or subcontractors, shall be entitled to compensation, workers compensation, or employee benefits of the other party by virtue of this Agreement.

**XIV. COUNTERPART SIGNATURE**

This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each counterpart shall be deemed an original and all of which shall constitute but one Agreement.

**XV. WRITTEN AMENDMENT/WAIVERS**

This Agreement cannot be amended, modified, supplemented or rescinded except in writing signed by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.

**XVI. GOVERNING LAW AND JURISDICTION**

This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee. Each party hereby consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, agrees that venue for any such action shall lie exclusively in such courts, and agrees that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto.

**XVII. ACCESS TO BOOKS AND RECORDS**

Until the expiration of four years after the furnishing of services pursuant to this Agreement, the parties shall upon written request, make available to the Secretary of Health and Human Services or the Comptroller General or their duly authorized representative the contract, books, documents, and records necessary to verify the nature and extent of the cost of such services. If either party carries out any of its obligations under this Agreement by means of a subcontract with a value of \$10,000 or more, that party agrees to include this requirement in any such subcontract.

**XVIII. CONSTRUCTION OF AGREEMENT**

The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement. This Agreement has been prepared on the basis of mutual understanding of the parties and shall not be construed against either party by reason of such party's being the drafter hereof.

**XIX. NON-EXCLUSIVITY**

Each party shall have the right to enter into similar agreements with other parties.

**XX. COMPLIANCE WITH PATIENT TRANSFER REQUIREMENTS**

All parties hereto agree that any patient transfers shall be in compliance with Federal Regulations, 42 U.S.C. 1395dd et seq. ("EMTALA") and any amendments thereto, and such other requirements as may be imposed by the Secretary of Health and Human Services, and any other applicable State patient transfer laws.

**XXI. PATIENT REFERRALS**

The parties agree that the benefits to either party hereunder do not require, are not payment for, and are not in any way contingent upon the admission, referral, or other arrangement for the provision of any item or service reimbursed under Medicare or Medicaid/TennCare.

**XXII. ENTIRE AGREEMENT**

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives on the last signature date specified below.

**FOR VANDERBILT UNIVERSITY**

Recommended by:



Marilyn A. Dubree, RN, MSN  
Director – Patient Care Services  
Chief Nursing Officer  
Vanderbilt University Hospital

8-2-00

Date



Corey Slovis, M.D.  
Chairman, Department of Emergency Medicine  
Vanderbilt University Hospital

8/4/00

Date



Terrell Smith, M.S.N, R.N.  
Administrative Director – Children's Hospital

7/27/00

Date

Approved by:

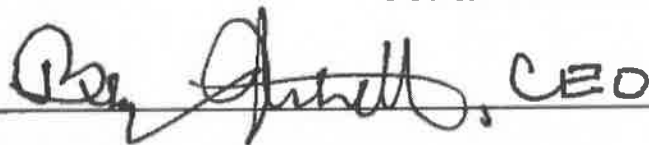


Norman B. Army  
Executive Vice President  
for Clinical Affairs

8/7/00

Date

**FOR HORIZON MEDICAL CENTER**

 CEO

8/11/00

Date

Date

*Gail England*

TENNESSEE EMERGENCY MEDICAL SERVICES FOR CHILDREN  
INTERFACILITY PEDIATRIC TRANSFER AGREEMENT  
BETWEEN  
VANDERBILT UNIVERSITY  
AND  
HORIZON MEDICAL CENTER

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 Horizon Medical Center  
 111 Hwy. 70 East  
 Dickson, TN 37055

VANDERBILT: Terrell Smith  
 Administrative Director, Vanderbilt Children's Hospital  
 1211 27<sup>th</sup> Avenue South  
 6111 VUH  
 Nashville, TN 37232-7000

with a copy to: Contracts Administration  
 Medical Center Office  
 Vanderbilt University  
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*Handwritten signature: Gail England*

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**XXII. ENTIRE AGREEMENT**

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives on the last signature date specified below.

**FOR VANDERBILT UNIVERSITY**

Recommended by:



Marilyn A. Dubree, RN, MSN  
Director – Patient Care Services  
Chief Nursing Officer  
Vanderbilt University Hospital

8-2-00

Date



Corey Slovis, M.D.  
Chairman, Department of Emergency Medicine  
Vanderbilt University Hospital

8/4/01

Date



Terrell Smith, M.S.N., R.N.  
Administrative Director – Children's Hospital

7/27/00

Date

Approved by:




Norman B. Army  
Executive Vice President  
for Clinical Affairs

8/7/00

Date

**FOR HORIZON MEDICAL CENTER**

 CEO

8/11/00

Date

Date

**C, Need--1.A.3.e.**  
**Letters of Intent & Qualifications**  
**Facility Protocols and Procedures**

## ***CURRICULUM VITAE***

Muhammad Sami Ismail, M.D.  
101 Wyn Oak Circle  
Nashville, TN 37205  
615-386-3685

**Born:** March 22, 1954  
Antioche, Turkey

**Citizenship:** U.S.A.

**Visa Type:** Permanent Resident

**Social Security:** 221-64-2442

**Marital Status:** Married, wife Hanan  
Three daughters

**Office:** Pediatrix Medical Group of TN  
2201 Murphy Ave. #207  
Nashville, TN 37203  
Office# (615) 342-4660  
Fax# (615) 342-4662

## **LICENSURE**


ECFMG - #284-659-0  
Virginia State Board of Medicine, #0101-036388, 2/84  
Delaware Board of Medicine, #C1002509, 9/84  
Tennessee Board of Medicine, #MD19241, 10/88  
Board Certified, American Board of Pediatrics #35796, 1987  
Board Certified, Neonatal/Perinatal Medicine #1758, 1987  
Maintenance of Certification (MOC) of the American Board of Pediatrics - 2009

## **EDUCATION**

Faculty of Medicine of Aleppo University, Syria  
1971-1977, M.D. Degree

## **MILITARY SERVICE RECORD**

None



7/20/12

**POST-DOCTORAL TRAINING**

Red Cross Children's Hospital, Pediatric Training (Aleppo, Syria) 1977-1979

Middlesborough Memorial Hospital Internal Medicine (visiting observer) Middlesborough, England 1979-1980

Darlington Memorial Hospital, Darlington, England 1980 (Passed PLAB exam for foreign graduates in England)

Practice in Critical Care Unit at Los Cedros Hospital, Buenos Aires, Argentina 1980-1981

Los Cedros Hospital, Buenos Aires, Argentina (clinical rotation critical care unit) 1980-1981

Wilmington Medical Center, Wilmington, DE (observer Pediatrics) 1981-1982 (passed VQE)

Wilmington Medical Center, Wilmington, DE Pediatric Residency 1982-1985

Medical College of Virginia, Richmond, VA Neonatology Fellow, 1985-1987

Henrico Doctors Hospital, Richmond, VA Clinical Neonatologist 1987-1989

Centennial The Women's Hospital, Nashville, TN Director of Neonatology 1989 – present

Summit Medical Center, Hermitage, TN 1989 – present

Southern Hills Medical Center, Nashville, TN 1989-2008

Hendersonville Medical Center, Hendersonville, TN 1992 – present

Nashville Memorial (Skyline Hospital), Nashville, TN 1992 – 2004

Metro General Hospital, Nashville, TN 1995 – present

Williamson Medical Center, Franklin, TN 2004 – present

Horizon Medical Center, Dickson, TN 2005 – present

StoneCrest Medical Center, Smyrna, TN 2006 – present

Middle TN Medical Center, Murfreesboro, TN 2007 – present

**ACADEMIC APPOINTMENTS**

Instructor of Pediatrics, Children's Medical Center, Medical College of Virginia, Richmond, VA  
July 1986 – June 1987

**POSITIONS HELD**

Director of Newborn Intensive Care Unit at Centennial The Women's Hospital

Director of Newborn Intensive Care Unit Transport Services  
*Curriculum Vitae – M. Sami Ismail, M.D.*  
Page 3

Director of Neonatal Nurse Practitioner Program  
President of Mid-TN Neonatology Associates  
Medical Director of Pediatrix Medical Group of TN  
Board of Trustee for Centennial Medical Center

### MEMBERSHIPS

American Medical Association  
American Academy of Pediatrics  
Tennessee Pediatric Society  
Davidson County Pediatric Association  
Arab American Medical Association  
Nashville Academy of Medicine  
Medical Director of Pediatric Nursing Specialist  
National Perinatal Association  
Centennial Board of Director  
Tennessee Perinatal Association  
District 4 Perinatal Section

### RESEARCH

Significance and Application of the Ancient Medicine of Arabs, 1974

Group B Strep Infection in Newborns (Early Diagnosis) Study, Medical Center of Delaware

CPT and Incidence of IVH/PVH in Neonates

Incidence of Biliary Slugs/Gallstones in Newborns Receiving HAL, Accepted for Presentation in Poster Session at the April 1987 SPR Conference in Anaheim, CA

### BIBLIOGRAPHY

Ismail, MS; Immunodeficiency Disease in Children, published by Aleppo University, 1977

Arectingy, R, Ismail, MS; Significance and Application of the Ancient Arab Medicine, published by the VI International Symposium of the Ancient Medicine of Arabs, sponsored by Aleppo University, 1974

Renewal No.

763064

State of Tennessee

Division Of Health Related Boards

LPEBSEC026

MD0000019241

This Certifies that

MUHAMMAD S ISMAIL, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as

required by the Tennessee Code Annotated and is a duly

authorized: MEDICAL DOCTOR

in the State of Tennessee through

MARCH 31, 2014



*Wing J. Dineen*  
DIRECTOR, HEALTH RELATED BOARDS

From: appsmail@abped.org  
To: neomomma@aol.com  
Subject: American Board of Pediatrics - MOC Enrollment License Verified  
Date: Mon, Dec 28, 2009 1:05 pm

---

Dr. Muhammad Sami Ismail:  
ABP ID # 204946

You have successfully completed the enrollment application process for Maintenance of Certification (MOC) of the American Board of Pediatrics (ABP).

Please take note of the following information regarding your next MOC Cycle dates. These dates represent the start and end of your MOC cycle. You may complete activities for credit only during this time. Your specific MOC requirements can be found with your ABP Portfolio.

MOC Cycle Dates                      January 1, 2010 through December 31, 2014

This e-mail is generated automatically, and replies sent to this address cannot be answered. If you have any questions regarding your enrollment status, please feel free to visit the ABP Web site ([www.abp.org](http://www.abp.org)) or e-mail us at [moc@abped.org](mailto:moc@abped.org).

The American Board of Pediatrics  
and its  
Subboard of Neonatal-Perinatal Medicine  
hereby declare that

Muhammad Sami Zmail, M.D.

who is certified in Neonatal-Perinatal Medicine  
has completed the maintenance of certification program  
as a Diplomate of  
the American Board of Pediatrics

No. 01758

October 7, 2009



W. Douglas Jones

Chair, American Board of Pediatrics

James C. Lockman

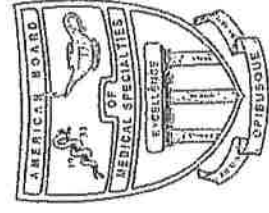
President, American Board of Pediatrics

Richard J. Martin

Chair, Subboard

Carol Caraccio

Secretary, American Board of Pediatrics



# The American Board of Pediatrics

hereby certifies that

Muhammad Sami Jamil, M.D.

has successfully fulfilled the requirements  
of this Board and  
is declared a

Diplomate of The American Board of Pediatrics

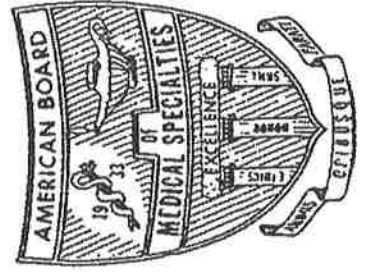
No. 35796

June 21, 1987

*Rebecca Bond*  
My Commission Expires Sept. 25, 2010



*Lawrence J. Lippert* President  
*Sam*  
*F. Chinn* Secretary



**Tennessee**  
*The Volunteer State*

**DRIVER LICENSE**

**074039251**

Class D

Endorsements NONE

Restrictions 01

Sex M Ht 5'08" Eyes GN

SSN ON FILE

Expires 03-22-2014

Issued 06-19-2008

Birthdate 03-22-1954



MUHAMMAD SAMI ISMAIL  
605 LINDEN SQUARE  
NASHVILLE, TN 37215



DL

*[Signature]*

EDUCATIONAL COMMISSION  
for  
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

MUHAMMAD SAMI ISMAIL

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,  
SUCCESSFULLY PASSED ITS EXAMINATIONS  
AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER

284-659-0

MEDICAL EXAMINATION

JANUARY 26, 1977

ENGLISH EXAMINATION

JANUARY 17, 1981

VALID THROUGH

JANUARY, 1983



*Madison B. Brown, Jr.*  
CHAIRMAN

*Ray L. Carter, M.D.*  
PRESIDENT

DATE ISSUED

SEP 30 1981

## **MICHAEL D. HAWKINS**

Home- 423 Wild Elm Street  
Franklin, TN 37064  
(615)472-8211  
Hawkins65@comcast.net

Office- 111 Highway 70 East  
Dickson, TN 37055  
(615)446-4400/fax (615)446-4234

**EMPLOYMENT**      Women's Health Center of Dickson, PLLC(sole proprietor)  
Dickson, Tennessee  
From January 2001 to present

Horizon Medical Group(multispecialty)  
Dickson, Tennessee  
From June 1996 to December 2000

Columbia Physician Services  
Nashville Memorial Hospital  
Madison, Tennessee  
From July 1995 to June 1996

**EDUCATION**      Residency, Obstetrics and Gynecology  
Vanderbilt University Medical Center  
Nashville, Tennessee  
From July 1991 to June 1995  
Resident Research Forum, Senior Resident Winner 1995

M.D., Emory University School of Medicine  
Atlanta, Georgia  
From August 1987 to May 1991  
Student Intern, Clinical Research Center  
Emory University Hospital  
From June 1988 to May 1989

B.A., Vanderbilt University  
From August 1984 to May 1987  
Major-Mathematics  
-Magna Cum Laude  
-Phi Beta Kappa  
-Phi Eta Sigma, Alpha Lambda Delta(freshman honoraries)  
-Dean's Select Scholarship(three years)

**PUBLICATIONS** Bonkovsky HL, Hawkins MD, Steinberg KK, et al. Prevalence and prediction of osteopenia in chronic liver disease. Hepatology 1990; 12:273.

Steinberg KK, Bonkovsky HL, Hawkins, MD. Osteocalcin and bone alkaline phosphatase in chronic liver disease. Clinical Chemistry 1990;36:990.

Steinberg KK, Hawkins MD, Bonkovsky HL. Decreased hepatic clearance of glycoproteins:a cause of increased alkaline phosphatase in cirrhosis(abstract). Hepatology 1989;10:680.

McQuaide BH, Hawkins MD, Banna MS. Shake-up in the core ionization of atomic zinc and cadmium. Chemical Physics Letters 1987;141:306.

McQuaide BH, Hawkins MD, Banna MS. Atomic cesium 3d core photoelectron spectrum. Physical Review A 1987;36:4498.

**PRESENTATIONS** Bonkovsky HL, Hawkins MD, Steinberg KK, et al. Prevalence and prediction of osteopenia in chronic liver disease. 40<sup>th</sup> Annual Meeting of the American Association for the Study of Liver Diseases, October 28-31, 1989. Chicago, Illinois.

McQuaide BH, Hawkins MD, Jenkins DE, et al. Argon 1s and shake-up photoelectron spectrum obtained with 3600 eV photons. 15<sup>th</sup> Annual NSLS Users Meeting, June 17-18, 1987. Long Island, New York.

**ORGANIZATIONS** American College of Obstetrics and Gynecology, Fellow  
Lonnie S. Burnett Society(Vanderbilt OB/GYN organization)

**PRIVILEGES** Horizon Medical Center-Active Staff, Chief Maternal/Child Division  
-Chairman, Peer Review Committee  
-Chief of Surgery Dept  
-Vice Chief of Staff

**CERTIFICATION** American Board of Obstetrics and Gynecology- active through December 31, 2016

**LICENSURE** Tennessee MD 26802-expires November 30, 2015

**Erin Steidl, DO, FACOG**  
2722 Edinboro Drive Arlington, TX 76012

682.554.9457

[steidl@swbell.net](mailto:steidl@swbell.net)

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### **Objective**

Caring, versatile physician seeking a position serving patients in a private practice or laborist setting

### **Qualifications**

Solid obstetrical and surgical skill set, including operative delivery, cesarean delivery, laparoscopy, vaginal and abdominal surgery  
Outstanding communication skills, able to establish rapport quickly with patients and staff  
Superior clinical judgment and decision making skills  
Reassuring bedside manner  
Some Spanish

### **Education and Employment**

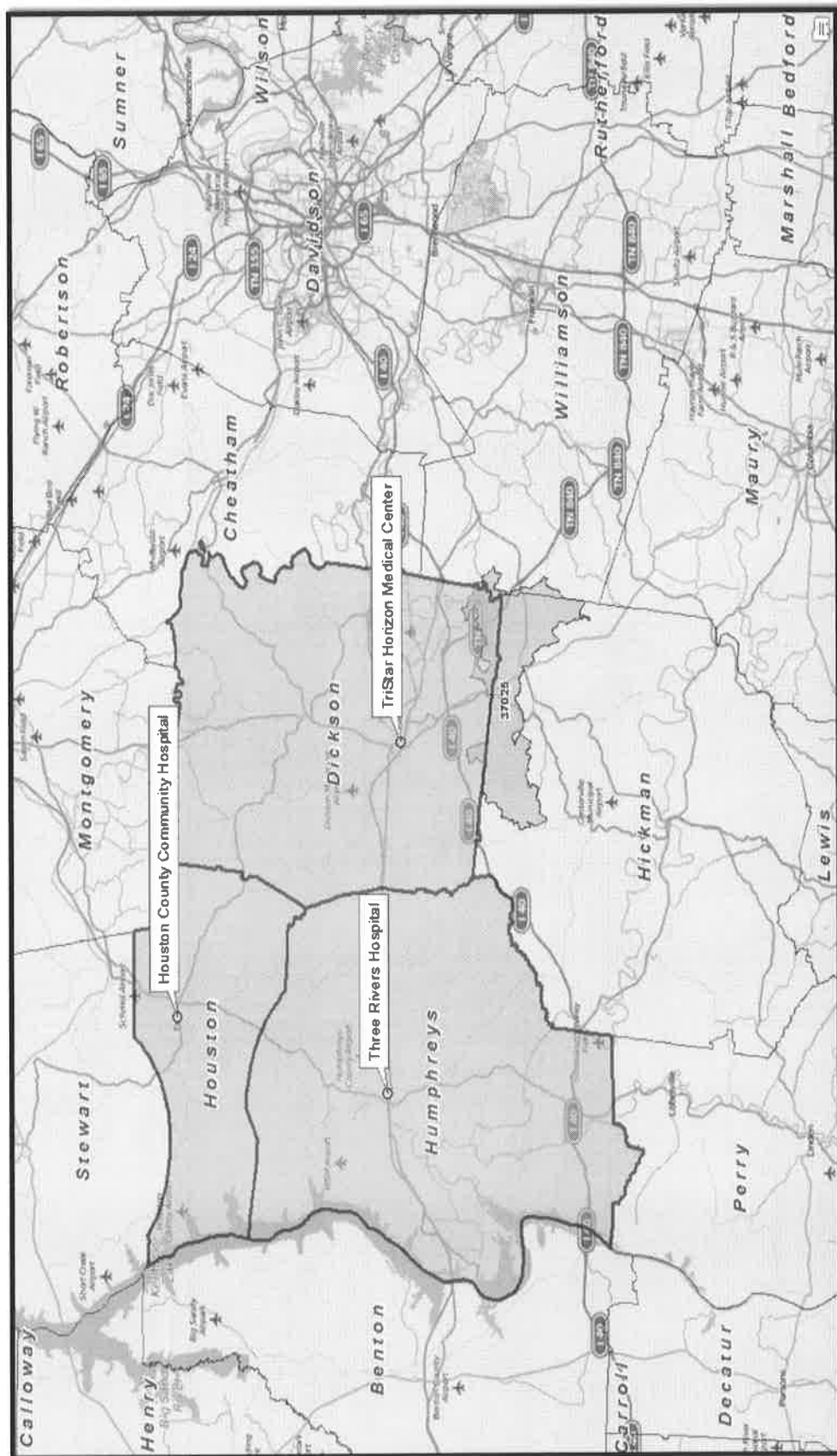
Arlington Obstetrics and Gynecology, Partner 2008-Current  
Arlington, TX  
Methodist Hospital of Dallas Obstetrics and Gynecology Residency Program  
Intern, Resident, Chief Resident 2004-2008  
Dallas, TX  
Doctor of Osteopathy, Texas College of Osteopathic Medicine 2000-2004  
Fort Worth, TX  
Research Assistant, Vanderbilt University School of Medicine Department of Molecular Physiology and Biophysics 1999-2000  
Nashville, TN  
Bachelor of Science in Biology, Lipscomb University 1995-1999  
Nashville, TN

### **Licensure, Certifications and Memberships**

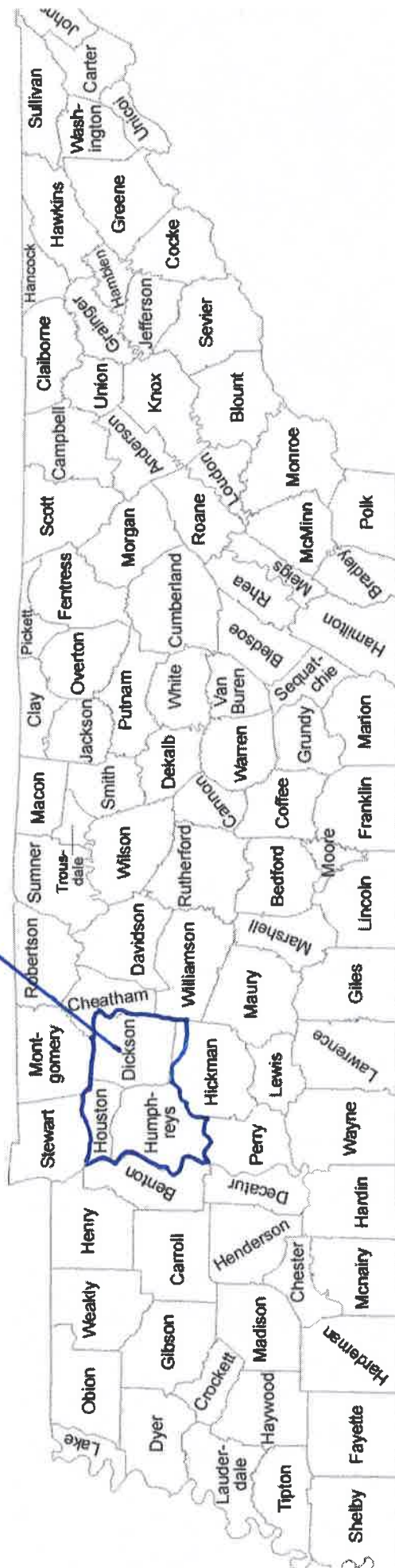
Fully licensed in the state of Texas  
Fellow of the American College of Obstetricians and Gynecologists  
Advanced Life Support in Obstetrics  
Advanced Cardiovascular Life Support/Basic Life Support  
Childbirth Injury, The Law and Perinatal Safety Course  
Served on the Electronic Medical Record and Service Excellence Committees for the Medical Clinics of North Texas  
Member of ACOG, AMA, TMA (Texas Medical Association), and TOMA (Texas Osteopathic Medical Association)

References Available Upon Request

**C, Need--3**  
**Service Area Maps**



TRISTAR HORIZON MEDICAL CENTER NICU  
PRIMARY SERVICE AREA



Printable Maps From:  
[terproof Paper.com](http://terproofpaper.com)

**C, Economic Feasibility--1**  
**Documentation of Construction Cost Estimate**

# C. ROSS ARCHITECTURE L.L.C.

October 13, 2015

**Subject: Verification of Construction Cost Estimate  
TriStar Horizon Medical Center  
Nursery Intensive Care Unit Expansion  
Dickson, Tennessee**

To Whom It May Concern:

C. Ross Architect L.L.C., an architectural firm in Nashville, Tennessee, has reviewed the construction cost data for the above referenced project. The stated construction cost for this renovation is approximately \$375,000.00. (In providing opinions of probable construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions, or the Contractor's method of pricing, or the Code Reviewer's interpretation at a later date of the requirements for the project, and that the Consultant's opinion of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warranty, expressed or implied, that the bids or the negotiated cost of the work will not vary from the Consultants opinion or probable construction cost.)

It is our opinion at this time the projected construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market. However, it should be noted that the construction costs re increasing rapidly due to economic factors beyond Contractor's controls.

The building codes applicable to this project will be:

**State:**

1. 2010 Guidelines for Design and Construction of Hospitals and Health Care Facilities
2. 2012 International Building Code
3. 2012 International Mechanical Code
4. 2012 International Plumbing Code
5. 2012 International Fuel and Gas Code
6. 2011 National Electric Code
7. 2012 NFPA 101 Life Safety Code
8. 1999 North Carolina Handicap Accessibility Code with 2004 Amendments
9. 2012 U S' Public health Code

**Federal:**

1. The Americans with Disabilities Act (ADA), Accessibility Guidelines for Buildings and Facilities – 2010 Edition

Sincerely,

C. ROSS ARCHITECTURE, L.L.C.



R. Christopher Ross, III, AIA

3807 Charlotte Avenue ▼ Nashville, Tennessee 37209

Phone: 615.385.1942 ▲ Fax: 615.385.1943 ▲ Mobile: 615.430.4072 ▲ Email: rossarch@comcast.net

**C, Economic Feasibility--2**  
**Documentation of Availability of Funding**

**C, Economic Feasibility--10**  
**Financial Statements**

**HCA HOLDINGS, INC.**  
**CONSOLIDATED INCOME STATEMENTS**  
**FOR THE YEARS ENDED DECEMBER 31, 2014, 2013 AND 2012**  
(Dollars in millions, except per share amounts)

	<u>2014</u>	<u>2013</u>	<u>2012</u>
Revenues before the provision for doubtful accounts .....	\$ 40,087	\$ 38,040	\$ 36,783
Provision for doubtful accounts .....	3,169	3,858	3,770
Revenues .....	<u>36,918</u>	34,182	33,013
Salaries and benefits .....	16,641	15,646	15,089
Supplies .....	6,262	5,970	5,717
Other operating expenses .....	6,755	6,237	6,048
Electronic health record incentive income .....	(125)	(216)	(336)
Equity in earnings of affiliates .....	(43)	(29)	(36)
Depreciation and amortization .....	1,820	1,753	1,679
Interest expense .....	1,743	1,848	1,798
Losses (gains) on sales of facilities .....	(29)	10	(15)
Losses on retirement of debt .....	335	17	—
Legal claim costs .....	78	—	175
	<u>33,437</u>	31,236	30,119
Income before income taxes .....	3,481	2,946	2,894
Provision for income taxes .....	1,108	950	888
Net income .....	<u>2,373</u>	1,996	2,006
Net income attributable to noncontrolling interests .....	498	440	401
Net income attributable to HCA Holdings, Inc. ....	<u>\$ 1,875</u>	<u>\$ 1,556</u>	<u>\$ 1,605</u>
Per share data:			
Basic earnings per share .....	\$ 4.30	\$ 3.50	\$ 3.65
Diluted earnings per share .....	\$ 4.16	\$ 3.37	\$ 3.49
Shares used in earnings per share calculations (in thousands):			
Basic .....	435,668	445,066	440,178
Diluted .....	450,352	461,913	459,403

The accompanying notes are an integral part of the consolidated financial statements.

**HCA HOLDINGS, INC.**  
**CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS**  
**FOR THE YEARS ENDED DECEMBER 31, 2014, 2013 AND 2012**  
**(Dollars in millions)**

	<u>2014</u>	<u>2013</u>	<u>2012</u>
Net income .....	<b>\$2,373</b>	\$1,996	\$2,006
Other comprehensive income (loss) before taxes:			
Foreign currency translation .....	(74)	18	37
Unrealized gains (losses) on available-for-sale securities .....	9	(7)	6
Defined benefit plans .....	(158)	134	(89)
Pension costs included in salaries and benefits .....	21	38	46
	<u>(137)</u>	<u>172</u>	<u>(43)</u>
Change in fair value of derivative financial instruments .....	(36)	3	(151)
Interest costs included in interest expense .....	132	131	122
	<u>96</u>	<u>134</u>	<u>(29)</u>
Other comprehensive income (loss) before taxes .....	(106)	317	(29)
Income taxes (benefits) related to other comprehensive income items .....	(40)	117	(12)
Other comprehensive income (loss) .....	<u>(66)</u>	<u>200</u>	<u>(17)</u>
Comprehensive income .....	<b>2,307</b>	2,196	1,989
Comprehensive income attributable to noncontrolling interests .....	498	440	401
Comprehensive income attributable to HCA Holdings, Inc. ....	<u><b>\$1,809</b></u>	<u><b>\$1,756</b></u>	<u><b>\$1,588</b></u>

The accompanying notes are an integral part of the consolidated financial statements.

**HCA HOLDINGS, INC.**  
**CONSOLIDATED BALANCE SHEETS**  
**DECEMBER 31, 2014 AND 2013**  
(Dollars in millions)

	<u>2014</u>	<u>2013</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents .....	\$ 566	\$ 414
Accounts receivable, less allowance for doubtful accounts of \$5,011 and \$5,488 ....	5,694	5,208
Inventories .....	1,279	1,179
Deferred income taxes .....	366	489
Other .....	1,025	747
	<u>8,930</u>	<u>8,037</u>
Property and equipment, at cost:		
Land .....	1,524	1,487
Buildings .....	11,941	11,211
Equipment .....	18,496	17,519
Construction in progress .....	1,019	856
	<u>32,980</u>	<u>31,073</u>
Accumulated depreciation .....	<u>(18,625)</u>	<u>(17,454)</u>
	<u>14,355</u>	<u>13,619</u>
Investments of insurance subsidiaries .....	494	448
Investments in and advances to affiliates .....	165	121
Goodwill and other intangible assets .....	6,416	5,903
Deferred loan costs .....	219	237
Other .....	620	466
	<u>\$ 31,199</u>	<u>\$ 28,831</u>
<b>LIABILITIES AND STOCKHOLDERS' DEFICIT</b>		
Current liabilities:		
Accounts payable .....	\$ 2,035	\$ 1,803
Accrued salaries .....	1,370	1,193
Other accrued expenses .....	1,737	1,913
Long-term debt due within one year .....	338	786
	<u>5,480</u>	<u>5,695</u>
Long-term debt .....	29,307	27,590
Professional liability risks .....	1,078	949
Income taxes and other liabilities .....	1,832	1,525
Stockholders' deficit:		
Common stock \$0.01 par; authorized 1,800,000,000 shares; outstanding 420,477,900 shares — 2014 and 439,604,000 shares — 2013 .....	4	4
Capital in excess of par value .....	—	1,386
Accumulated other comprehensive loss .....	(323)	(257)
Retained deficit .....	(7,575)	(9,403)
Stockholders' deficit attributable to HCA Holdings, Inc. ....	(7,894)	(8,270)
Noncontrolling interests .....	1,396	1,342
	<u>(6,498)</u>	<u>(6,928)</u>
	<u>\$ 31,199</u>	<u>\$ 28,831</u>

The accompanying notes are an integral part of the consolidated financial statements.

**HCA HOLDINGS, INC.**  
**CONSOLIDATED STATEMENTS OF STOCKHOLDERS' DEFICIT**  
**FOR THE YEARS ENDED DECEMBER 31, 2014, 2013 AND 2012**  
**(Dollars in millions)**

	Equity (Deficit) Attributable to HCA Holdings, Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Deficit	Equity Attributable to Noncontrolling Interests	Total
	Shares (000)	Par Value					
Balances, December 31, 2011	437,478	\$ 4	\$ 1,601	\$(440)	\$ (9,423)	\$1,244	\$(7,014)
Comprehensive income				(17)	1,605	401	1,989
Share-based benefit plans	5,722		169				169
Distributions					(3,142)	(401)	(3,543)
Other			(17)			75	58
Balances, December 31, 2012	443,200	4	1,753	(457)	(10,960)	1,319	(8,341)
Comprehensive income				200	1,556	440	2,196
Repurchase of common stock	(10,656)		(500)				(500)
Share-based benefit plans	7,060		139				139
Distributions						(435)	(435)
Other			(6)		1	18	13
Balances, December 31, 2013	439,604	4	1,386	(257)	(9,403)	1,342	(6,928)
Comprehensive income				(66)	1,875	498	2,307
Repurchase of common stock	(28,583)		(1,701)		(49)		(1,750)
Share-based benefit plans	9,457		321				321
Distributions						(442)	(442)
Other			(6)		2	(2)	(6)
Balances, December 31, 2014	420,478	\$ 4	\$ —	\$(323)	\$ (7,575)	\$1,396	\$(6,498)

The accompanying notes are an integral part of the consolidated financial statements.

**HCA HOLDINGS, INC.**  
**CONSOLIDATED STATEMENTS OF CASH FLOWS**  
**FOR THE YEARS ENDED DECEMBER 31, 2014, 2013 AND 2012**  
(Dollars in millions)

	<u>2014</u>	<u>2013</u>	<u>2012</u>
<b>Cash flows from operating activities:</b>			
Net income .....	\$ 2,373	\$ 1,996	\$ 2,006
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable .....	(3,645)	(4,395)	(3,896)
Provision for doubtful accounts .....	3,169	3,858	3,770
Accounts receivable, net .....	(476)	(537)	(126)
Inventories and other assets .....	(232)	(19)	(122)
Accounts payable and accrued expenses .....	444	142	355
Depreciation and amortization .....	1,820	1,753	1,679
Income taxes .....	(83)	143	96
Losses (gains) on sales of facilities .....	(29)	10	(15)
Losses on retirement of debt .....	335	17	—
Legal claim costs .....	78	—	175
Amortization of deferred loan costs .....	42	55	62
Share-based compensation .....	163	113	56
Other .....	13	7	9
Net cash provided by operating activities .....	<u>4,448</u>	<u>3,680</u>	<u>4,175</u>
<b>Cash flows from investing activities:</b>			
Purchase of property and equipment .....	(2,176)	(1,943)	(1,862)
Acquisition of hospitals and health care entities .....	(766)	(481)	(258)
Disposal of hospitals and health care entities .....	51	33	30
Change in investments .....	(37)	36	16
Other .....	10	9	11
Net cash used in investing activities .....	<u>(2,918)</u>	<u>(2,346)</u>	<u>(2,063)</u>
<b>Cash flows from financing activities:</b>			
Issuances of long-term debt .....	5,502	—	4,850
Net change in revolving bank credit facilities .....	440	970	(685)
Repayment of long-term debt .....	(5,164)	(1,662)	(2,441)
Distributions to noncontrolling interests .....	(442)	(435)	(401)
Payment of debt issuance costs .....	(73)	(5)	(62)
Repurchases of common stock .....	(1,750)	(500)	—
Distributions to stockholders .....	(7)	(16)	(3,148)
Income tax benefits .....	134	113	174
Other .....	(18)	(90)	(67)
Net cash used in financing activities .....	<u>(1,378)</u>	<u>(1,625)</u>	<u>(1,780)</u>
Change in cash and cash equivalents .....	152	(291)	332
Cash and cash equivalents at beginning of period .....	414	705	373
Cash and cash equivalents at end of period .....	<u>\$ 566</u>	<u>\$ 414</u>	<u>\$ 705</u>
Interest payments .....	\$ 1,758	\$ 1,832	\$ 1,723
Income tax payments, net .....	\$ 1,057	\$ 694	\$ 618

The accompanying notes are an integral part of the consolidated financial statements.

BALANCE SHEET  
ASSETS

HORIZON MEDICAL CENTER  
FINANCIAL STATEMENT  
AS OF 06/30/15

CO SO B00 R00 D000 U02902 C0ID 36243  
07/11/15

BEGIN	CURRENT MONTH CHANGE	ENDING	ENDING	YEAR TO DATE CHANGE	BEGIN
5,436	3,851	9,287	9,287	13,178-	22,465
CURRENT ASSETS - CASH & CASH EQUIVALENTS MARKETABLE SECURITIES					
21,488,620	1,935,138	23,423,758	23,423,758	1,860,761	21,562,997
12,976,034-	2,067,629-	15,043,663-	15,043,663-	1,923,776-	13,119,887-
8,512,586	132,491-	8,380,095	8,380,095	63,015-	8,443,110
PATIENT ACCOUNTS RECEIVABLES PATIENT RECEIVABLES LESS ALLOW FOR GOVT RECEIVABL LESS ALLOWS - BAD DEBT NET PATIENT RECEIVABLES					
36,834	122,425	159,259	159,259	315,943	156,684-
36,834	122,425	159,259	159,259	315,943	156,684-
8,549,420	10,066-	8,539,354	8,539,354	252,928	8,286,426
2,419,223	33,149	2,452,372	2,452,372	48,931	2,403,441
228,447	29,541-	198,906	198,906	765,915-	964,821
28,767	14,383-	14,384	14,384	22,221-	36,605
11,231,293	16,990-	11,214,303	11,214,303	499,455-	11,713,758
TOTAL CURRENT ASSETS					
PROPERTY, PLANT & EQUIPMENT					
5,506,361		5,506,361	5,506,361		5,506,361
47,084,998	4,451,956	51,536,954	51,536,954	4,451,956	47,084,998
38,942,856	734,772	39,677,628	39,677,628	826,899	38,850,729
1,274,274		1,274,274	1,274,274	256,729	1,017,545
210,895	183,286	394,181	394,181	385,931	8,250
93,019,384	5,370,014	98,389,398	98,389,398	5,921,515	92,467,883
58,794,165-	206,452-	59,000,617-	59,000,617-	1,258,103-	57,742,514-
34,225,219	5,163,562	39,388,781	39,388,781	4,663,412	34,725,369
LESS ACCUMULATED DEPRECIATION NET PP&E					
OTHER ASSETS					
INVESTMENTS					
16,029,952		16,029,952	16,029,952		16,029,952
16,029,952		16,029,952	16,029,952		16,029,952
16,029,952		16,029,952	16,029,952		16,029,952
61,486,464	5,146,572	66,633,036	66,633,036	4,163,957	62,469,079
GRAND TOTAL ASSETS					



U02902

C0 S0 B00 R00 D000 U02902 C0ID 36243

07/11/15

HORIZON MEDICAL CENTER  
MONTHLY OPERATING STATEMENTS  
FOR PERIODS ENDING 06/30/15

## SUMMARY P &amp; L STATEMENT

		CURRENT MONTH		THIS YEAR		YEAR TO DATE		BUDGET		LAST YEAR	
		LAST YEAR	BUDGET	THIS YEAR		THIS YEAR		BUDGET		LAST YEAR	
<b>REVENUES</b>											
1,909,624	2,284,552	2,249,350		14,181,848		14,175,364		12,882,317			
10,966,310	12,247,616	11,871,948		70,259,169		73,010,006		68,802,549			
12,875,934	14,532,168	14,121,298		84,441,017		87,185,370		81,684,866			
19,343,706	21,633,698	22,366,885		130,611,475		122,536,645		111,593,647			
32,219,640	36,165,866	36,488,183		215,052,492		209,722,015		193,278,513			
44,272	44,272	47,559		293,401		281,138		281,138			
32,263,912	36,210,138	36,535,742		215,345,893		210,003,153		193,559,651			
<b>REVENUE DEDUCTIONS</b>											
7,789,209	9,019,543	9,338,180		55,495,366		57,424,819		53,957,313			
45,888	68,410	208,967		583,676		167,600		441,132			
250,047	242,750	198,791		1,287,236		1,569,346		1,477,508			
186,799-	186,799-	279,897-		747,547-		471,137-		439,795-			
13,728,108	15,252,050	14,408,028		92,345,669		85,381,609		75,299,498			
432,922	392,969	158,974		1,942,952		2,417,188		1,923,858			
3,482,321	4,358,179	2,724,699		19,718,440		23,337,132		21,478,863			
855,218	1,186,655	2,735,684		7,369,322		4,759,025		5,341,570			
26,396,914	30,333,757	29,493,426		177,995,114		174,585,582		159,479,947			
5,866,998	5,876,381	7,042,316		37,350,779		35,417,571		34,079,704			
<b>OPERATING COSTS</b>											
1,991,654	2,156,131	2,300,723		12,856,159		12,635,049		12,162,416			
70,745	72,160	79,812		438,622		432,960		424,470			
526,481	373,003	572,666		3,593,544		3,413,016		3,428,905			
833,571	776,147	917,305		4,825,553		4,589,038		4,872,489			
361,364	288,073	261,482		1,581,120		1,721,385		1,880,599			
663,781	749,205	761,119		4,537,275		4,520,790		4,225,828			
194,084	198,578	266,900		1,279,944		1,222,001		1,159,554			
33,009	30,541	39,542		205,053		178,380		174,280			
148,524	159,635	145,730		782,622		939,952		910,633			
50,182	55,564	54,179		333,466		333,384		301,091			
<b>INVESTMENT INCOME</b>											
41,753	49,567	51,053		309,045		297,402		301,531			
72,659	104,080	116,411		643,119		714,235		553,846			
4,987,807	5,012,684	5,566,922		31,385,522		30,997,592		30,395,642			
879,191	863,697	1,475,394		5,965,257		4,419,979		3,684,062			
281,556	286,888	286,059		1,699,360		1,731,264		1,738,084			
<b>OTHER NON-OPERATING EXPENSE</b>											
304,011	305,684	298,303		1,812,969		1,835,050		1,829,135			
389,219	412,473	410,552		2,468,597		2,474,702		2,348,797			
974,786	1,005,045	994,914		5,980,926		6,041,016		5,916,016			
95,595-	141,348-	480,480		15,669-		1,621,037-		2,231,954-			
95,595-	141,348-	480,480		15,669-		1,621,037-		2,231,954-			

**C, Orderly Development--7(C)**  
**Licensing & Accreditation Inspections**



STATE OF TENNESSEE  
**DEPARTMENT OF HEALTH**  
WEST TENNESSEE HEALTH CARE FACILITIES  
781-B AIRWAYS BOULEVARD  
JACKSON, TENNESSEE 38301-3203

*Cope:  
✓ Lma  
✓ Sherice  
9/3/08*

August 27, 2008

Mr. John Marshall, Administrator  
Horizon Medical Center  
111 Hwy 70 East  
Dickson, TN 37055

**RE: Licensure Surveys**

Dear Mr. Marshall:

On June 4, 2008, licensure surveys were completed at your facility. Your plans of correction for these surveys have been received and were found to be acceptable.

Thank you for the consideration shown during this survey.

Sincerely,

*Celia Skelley/TW*  
Celia Skelley, MSN, RN  
Public Health Nurse Consultant 2

CES/TJW

August 21, 2008

Ms. Celia Skelley, MSN, RN  
State of Tennessee  
Department of Health  
West Tennessee Health Care Facility  
781-B Airways Boulevard  
Jackson, TN 38301-3203

**RE: Licensure & Fire Safety Surveys**

Dear Ms. Skelley:

Enclosed is Horizon Medical Center's Plan of Correction for the deficiencies cited during our June 4, 2008 annual licensure survey.

Should you find that you have any questions, please feel free to call me at 615-441-2357..

Sincerely,



John Marshall, CEO

**August 21, 2008**

**Ms. Celia Skelley, MSN, RN  
State of Tennessee  
Department of Health  
West Tennessee Health Care Facility  
781-B Airways Boulevard  
Jackson, TN 38301-3203**

**RE: Licensure & Fire Safety Surveys**

**Dear Ms. Skelley:**

**Enclosed is Horizon Medical Center's Plan of Correction for the deficiencies cited during our June 4, 2008 annual licensure survey.**

**Should you find that you have any questions, please feel free to call me at 615-441-2357..**

**Sincerely,**



**John Marshall, CEO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/04/2008
NAME OF PROVIDER OR SUPPLIER  HORIZON MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HIGHWAY 70 EAST DICKSON, TN 37055		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 732	<p>1200-8-1-.06 (9)(b) Basic Hospital Functions</p> <p>(9) Food and Dietetic Services.</p> <p>(b) The hospital must designate a person to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be:</p> <ol style="list-style-type: none"> <li>1. A dietitian; or</li> <li>2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or</li> <li>3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian.</li> </ol> <p>This Rule is not met as evidenced by: Based on review of personnel files and interview, it was determined the facility failed to ensure the food and dietetic services Director met these requirements for the position.</p> <p>The findings included:</p> <p>Review of personnel file for Employee #17 documented the employee had a job description of Food and Nutrition Director. Review of the file revealed no documentation of a state-approved course of classroom instruction of food service supervision.</p>	H 732	<p>1200-8-1-.06 (9) (b) Basic Hospital Functions</p> <p>(9) Food and Dietetic Services</p> <p>Horizon Medical Center has a designated Director of Food and Nutrition Services who holds an Associate's Degree in Culinary Arts. His current level of training has fully met the Certifying Board for Dietary Managers' requirements, and he has been accepted to sit for the Certified Dietary Manager's Credentialing Exam on October 25, 2008. This program is accredited by the National Commission for Certifying Agencies. A copy of his certificate as a Certified Dietary Manager (CDM) will be maintained in his personnel file for review upon receipt.</p> <p>The Director of Food and Nutrition Services has a qualified dietician available on-site for consultation when needed.</p>	<p>The application for taking the CDM exam was accepted on 7/21/08.</p> <p>The date of the CDM exam will be 10/25/08</p>

Division of Health Care Facilities

*F. H. Marshall*

TITLE CEO

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

8-21-2008

STATE FORM

6500

3L3811

If continuation sheet 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING - _____ B. WING - _____		(X3) DATE SURVEY COMPLETED  06/04/2008
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H 732	Continued From page 1  During an interview on 6/4/08 at 1:45 PM in the conference room, the Food and Nutrition Director stated he had not attended a state-approved course of classroom instruction in food service supervision.	H 732			

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008
NAME OF PROVIDER OR SUPPLIER  HORIZON MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HIGHWAY 70 EAST DICKSON, TN 37055		
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H 872	1200-8-1-.08 (2) Building Standards  (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.  This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to maintain the physical environment.  The findings include:  On 6/4/08 at approximately 9:30 AM, inspection of the ceiling tiles located throughout the facility revealed water stain ceiling tiles. TDOH 1200-8-1-.8(2)	H-872	1200-8-1-.08 (2) Building Standards  The hospital acknowledges the opportunity to improve the overall hospital environment by the ongoing replacement of ceiling tiles noted to be stained or damaged.  A tour of the entire facility was completed and stained ceiling tiles were identified for replacement. It is anticipated that 100% of the tiles identified during this tour will be replaced by 8/31/08.  Ongoing monitoring throughout the hospital is done departmentally on a monthly basis by each Director completing an Environmental and Infection Control Survey. It has been determined that additional education and reinforcement of this process is needed to promote a more timely reporting of this environmental issue. An educational review of our process was presented during the Management Meeting on 8/20/08.	8/31/08	
H 893	1200-8-1-.08 (23) Building Standards  (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.  This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to maintain the negative air pressure.  The findings include:  On 6/4/08 at approximately 11:30 AM, inspection of the 1st floor South soiled utility room revealed no exhaust fan installed in the room. TDOH	H-893	The Director of Plant Operations, or designee will audit compliance at least quarterly during Environmental Tour Surveys.  A multidisciplinary team consisting of the Safety Officer, Infection Control Coordinator, Environmental Services Director, and members of the Quality Department also conduct departmental Environmental Rounds to monitor hospital compliance.  1200-8-1-.08 (23) Building Standards  The 1 <sup>st</sup> floor South soiled utility room was relocated to a room where negative air pressure can be maintained.	Ongoing	8/20/08

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FORM

6899

8NL821

If continuation sheet 1 of 5

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008
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H 893	Continued From page 1 1200-8-1-.08(23)	H 893			
H 901	1200-8-1-.09 (1) Life Safety  (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.  This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to comply with the life safety codes as required..  The findings include:  On 6/4/08 at approximately 8:00 AM, inspection of the cinder block fire wall located above the fire doors next to the 2nd floor classroom revealed the 2" metal conduit was not sealed at the end. NFPA 101, 8.5.3.1  Inspection of the 2 hr fire wall located between the MOB and fast track corridors revealed the fire door's fire rating label was missing. NFPA 80, 1-5.1  Inspection of the standpipes located throughout the facility revealed the end caps were missing. NFPA 25, 6-2.1  Inspection of the 1st floor 2 hr fire wall (cinder block) located between the old main and the South corridors revealed 1/2" penetration in the wall. NFPA 101, 8.5.3.1	H-901	1200-8-1-.09 (1) Life Safety  It is the goal of Horizon Medical Center to fully comply with the requirements outlined in the Life Safety Code.  The 2" metal conduit in the fire wall near the 2nd floor classroom was sealed.  Guardian Fire Testing is under contract to inspect all of the hospital's fire doors for life safety code compliance including appropriate fire rating labeling. This project began on 6/12/08, and is not yet completed due to the contractor's scheduling difficulties. A second contractor is being considered for completion of this project.  100% of the building's standpipes were inspected. Those with missing brass end caps were replaced with plastic end caps.  The 1/2" penetration in the fire wall between the old main and South corridor has been repaired.	8/8/08  Anticipated completion by 9/19/08  7/24/08  8/8/08	

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008	
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H 901	<p>Continued From page 2</p> <p>Inspection of the 1st floor 2 hr fire wall (cinder block) located in the in-patient nursing managers corridor revealed the top of the sprinkler pipe was not sealed. The 1/2" and 6" metal conduits ends were not sealed. NFPA 101, 8.5.3.1</p> <p>Inspection of the roof top heliport revealed the 2 exit signs were not illuminated and legible. NFPA 101, 7.10.5.1 and NFPA 101, 7.10.3.1</p> <p>Inspection of cardiac rehab revealed the sprinklers were dirty (lint). NFPA 25, 5.2.1.1.1</p> <p>Inspection of the education department revealed the sprinklers were dirty (lint). NFPA 25, 5.2.1.1.1</p> <p>Inspection of the mechanical rooms located throughout the facility revealed portions of the ceilings deck support beams were missing the 2. hr fire coating. NFPA 220</p> <p>Inspection of equipment room 9 revealed the 2 hr cinder block fire wall had a 2" x 4" penetration. NFPA 101, 8.5.3.1</p> <p>Inspection of the 2nd floor West corridor (exit) fire door revealed the door did not close within the door frame. NFPA 80, 15.1.4</p> <p>Inspection of the 2nd floors' main equipment room's fire wall ((2) 5/8" drywall) revealed the 2" metal conduit end was not sealed. NFPA 101, 8.5.3.1</p> <p>Inspection of the OB cat walk exit canopy revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2</p>			H 901	<p>The 1/2" and 6" metal conduits ends of the sprinkler pipe located in the in-patient nursing manager's corridor have both been sealed.</p> <p>The exit signs on the roof top heliport were inspected and found to be illuminated. However, it was noted that the red plastic backdrop was faded by the sun, thus required replacement for proper illumination of signage.</p> <p>The sprinkler heads in cardiac rehab have been cleaned.</p> <p>The sprinkler heads in the education department have been cleaned.</p> <p>The Environmental Services Department staff have been re-educated regarding the importance of maintaining clean sprinkler heads as part of their normal routine cleaning procedure.</p> <p>The Environmental Services Director will monitor compliance during his monthly rounds. Compliance will also be monitored during the interdisciplinary team's Environmental Rounds.</p> <p>The mechanical rooms throughout the facility were inspected. A contractor was hired to re-insulate the decking and beams where needed to meet code requirements.</p> <p>The 2"x4" penetration in the fire wall noted in equipment room #9 has been repaired.</p> <p>The 2nd floor fire door on the West corridor did not come to a positive latch due to new carpet installation. The carpet transition piece was replaced to allow the door to close to a positive latch.</p> <p>Going forward, the Director of Plant Operations, or designee will immediately inspect upon job completion any fire door potentially affected by a change in flooring material.</p>		<p>8/8/08</p> <p>7/19/08</p> <p>8/20/08</p> <p>8/20/08</p> <p>8/20/08</p> <p>Ongoing</p> <p>7/11/08</p> <p>8/8/08</p> <p>7/14/08</p> <p>Ongoing</p>

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008
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H 901	Continued From page 3  Inspection of the ER ambulance and ER main entrance canopies revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2  Inspection of the surgery oxygen storage room revealed 2 unsecured oxygen cylinders. NFPA 7.1.3.4  Inspection of the 1st floor North exit stairwell revealed the fire wall had a 1/8" crack down the wall. NFPA 101, 8.5.3.1  Inspection of the 1st floor West supply (319) and in-patient rehab supply rooms revealed no smoke detectors installed in the rooms. NFPA 101, 9.6.2.10.1  Inspection of equipment room 1 revealed 3 electrical j-boxes with no covers installed. NFPA 70, 314.28(3)(c)  Inspection of equipment room 1 revealed the heating and cooling duct flange located at the ceiling deck had a 1/2" penetration. NFPA 101, 8.5.3.1  Inspection of the main boiler room revealed 2 hr cinder block fire wall had a 3" x 3" penetration. The 5" metal pipe was not sealed at the fire wall. NFPA 101, 8.5.3.1  Inspection of equipment rooms 10 and 11 revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2  Inspection of the kitchen revealed no C class portable fire extinguisher installed. NFPA 10, 4.1	H 901	The 2" metal conduit end located in the fire wall of the 2 <sup>nd</sup> floor's main equipment room has been sealed.  The sprinkler heads in the OB Cat-walk exit canopy are contracted to be replaced with new moisture-resistant heads.  The sprinkler heads in the ER ambulance and ER main entrance canopies are contracted to be replaced with new moisture-resistant heads.  The two oxygen cylinders located in the surgery oxygen storage room noted to be unsecured by the surveyor were immediately secured.  The Surgery Director re-educated the Operating Room staff at the August staff meeting regarding safe oxygen storage practices. Additional educational signage was also posted in the oxygen storage room.  A contractor is scheduled to inspect the 1/8" crack in the wall in the North exit stairwell and provide an estimate for repair on 8/22/08.  The smoke detectors needed in the in-patient rehab supply rooms were added to our worklist for the hospital-wide fire and security upgrades presently being completed by Simplex Grinnell.  The three electrical j-boxes with missing covers in equipment room #1 had covers installed immediately following the survey on 6/4/08.  The 1/2" penetration in the heating and cooling duct flange in equipment room #1 has been repaired.	8/8/08  Anticipated completion by 8/31/08.  Anticipated completion by 8/31/08.  6/4/08  8/20/08  Anticipated completion 9/5/08.  Anticipated completion 9/5/08.  6/4/08  8/08/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008	
NAME OF PROVIDER OR SUPPLIER  HORIZON MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 111 HIGHWAY 70 EAST DICKSON, TN 37055			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
H 901	<p>Continued From page 4</p> <p>Inspection of the kitchen revealed the sprinklers were dirty. NFPA 25, 5.2.1.1.2</p> <p>Observation of the records revealed no biannual sensitivity test were conducted on the smoke detectors. NFPA 72, 10.4.3.2.2</p> <p>Observation of the records revealed the 5 year sprinkler obstruction investigation was overdue. NFPA 25, 13.2.1</p>			H 901	<p>The 5" metal pipe in the main boiler room fire wall was sealed.</p> <p>The sprinkler heads in equipment rooms #10 and #11 are contracted to be replaced with new moisture-resistant heads.</p> <p>A "C" Class portable fire extinguisher was installed in the kitchen.</p> <p>Kitchen employees were educated regarding the appropriate time and procedure for using a "C" Class fire extinguisher.</p> <p>Going forward, "C" Class fire extinguisher training will be conducted by the Safety Officer, or designee during new hire departmental orientation and at least annually for all kitchen employees.</p> <p>Fire extinguishers monitoring will be done by the Plant Operations Director, or designee monthly.</p> <p>The Kitchen sprinkler heads have been cleaned. A contractor has been contacted for a quote on replacing our existing sprinkler heads with recessed sprinkler heads within the kitchen environment.</p> <p>A contract has been initiated for 100% of the smoke detectors hospital-wide to be sensitivity tested on 8/22/08. Going forward, this company will do sensitivity testing on a portion of the building each quarter to ensure that the entire building's sensitivity testing is completed at least biannually.</p> <p>A five year sprinkler obstruction investigation was completed on 8/8/08. A reminder for re-inspection in the year 2013 was placed on the Building Maintenance Program.</p>		<p>8/8/08</p> <p>Anticipated completion by 8/31/08</p> <p>7/29/08</p> <p>7/31/08</p> <p>Ongoing</p> <p>Ongoing</p> <p>08/20/08</p> <p>Anticipated completion by 8/31/08</p> <p>8/8/08</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008	
NAME OF PROVIDER OR SUPPLIER  HORIZON MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 111 HIGHWAY 70 EAST DICKSON, TN 37055			
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				H 901	<p>All of the repairs for the above mentioned fire wall penetrations and conduit sealings were completed using a UL approved Hilti-firestop system.</p> <p>Going forward, the Director of Plant Operations will require all contractors to report to Plant Ops prior to the start of a project, and at the completion of the project to better monitor for fire wall penetrations.</p> <p>All of the above mentioned findings will be included in the checklist for the Environmental Tour surveys conducted by the Director of Plant Operations, or his designee quarterly and as needed, to better ensure ongoing compliance.</p>		<p>8/8/08</p> <p>Ongoing</p> <p>Ongoing</p>



STATE OF TENNESSEE  
**DEPARTMENT OF HEALTH**  
WEST TENNESSEE HEALTH CARE FACILITIES  
781-B AIRWAYS BOULEVARD  
JACKSON, TENNESSEE 38301-3203

Cyber-Mark  
9/29/08

September 22, 2008

Mr. John Marshall, Administrator  
Horizon Medical Center  
111 Hwy 70 East  
Dickson, TN 37055

Dear Mr. Marshall:

On **September 15, 2008**, a surveyor from our office completed a revisit to verify that your facility had achieved and maintained compliance. Based on our revisit, we found that your facility had demonstrated compliance with deficiencies cited on the **fire safety licensure survey** completed on **June 4, 2008**.

If this office may be of any assistance to you, please call 731-421-5113.

Sincerely,

A handwritten signature in cursive script that reads "Celia Skelley" followed by a stylized monogram "HTW".

Celia Skelley, MSN, RN  
Public Health Nurse Consultant 2

CS/TW



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
WEST TENNESSEE HEALTH CARE FACILITIES  
781-B AIRWAYS BOULEVARD  
JACKSON, TENNESSEE 38301-3203

June 9, 2008

Mr. John Marshall, Administrator  
Horizon Medical Center  
111 Hwy 70 East  
Dickson, TN 37055

**RE: Licensure & Fire Safety Surveys**

Dear Mr. Marshall:

Enclosed is the statement of deficiencies for the licensure surveys completed at your facility on June 4, 2008. Based upon 1200-8-1, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates and signature within **ten (10) days from the date of this letter.**

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. **Enter on the right side of the State Form, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date.** The completion date can be no longer than **45 days from the day of survey.** Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-421-5113.

Sincerely,

*Celia Skelley* TW

Celia Skelley, MSN, RN  
Public Health Consultant Nurse 2

CS/TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNP53129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/04/2008</b>
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H 732	<p>1200-8-1-.06 (9)(b) Basic Hospital Functions</p> <p>(9) Food and Dietetic Services.</p> <p>(b) The hospital must designate a person to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be:</p> <ol style="list-style-type: none"> <li>1. A dietitian; or</li> <li>2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or</li> <li>3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian.</li> </ol> <p>This Rule is not met as evidenced by: Based on review of personnel files and interview, it was determined the facility failed to ensure the food and dietetic services Director met these requirements for the position.</p> <p>The findings included:</p> <p>Review of personnel file for Employee #17 documented the employee had a job description of Food and Nutrition Director. Review of the file revealed no documentation of a state-approved course of classroom instruction of food service supervision.</p>	H 732			

Division of Health Care Facilities

TITLE

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

3L3811

If continuation sheet 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNP53129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2008</b>
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H 732	Continued From page 1  During an interview on 6/4/08 at 1:45 PM in the conference room, the Food and Nutrition Director stated he had not attended a state-approved course of classroom instruction in food service supervision.	H 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNP53129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/04/2008</b>
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H 872	<p>1200-8-1-.08 (2) Building Standards</p> <p>(2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.</p> <p>This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to maintain the physical environment.</p> <p>The findings include:</p> <p>On 6/4/08 at approximately 9:30 AM, inspection of the ceiling tiles located throughout the facility revealed water stain ceiling tiles. TDOH 1200-8-1-.8(2)</p>	H 872			
H 893	<p>1200-8-1-.08 (23) Building Standards</p> <p>(23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor 's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.</p> <p>This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to maintain the negative air pressure.</p> <p>The findings include:</p> <p>On 6/4/08 at approximately 11:30 AM, inspection of the 1st floor South soiled utility room revealed no exhaust fan installed in the room. TDOH</p>	H 893			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6000

8NL621

If continuation sheet 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TNP53129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/04/2008</b>
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H 893	Continued From page 1 1200-8-1-.08(23)	H 893			
H 901	1200-8-1-.09 (1) Life Safety  (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.  This Rule is not met as evidenced by: Based on observation and inspection it was determined the facility failed to comply with the life safety codes as required..  The findings include:  On 6/4/08 at approximately 8:00 AM, inspection of the cinder block fire wall located above the fire doors next to the 2nd floor classroom revealed the 2" metal conduit was not sealed at the end. NFPA 101, 8.5.3.1  Inspection of the 2 hr fire wall located between the MOB and fast track corridors revealed the fire door's fire rating label was missing. NFPA 80, 1-5.1  Inspection of the standpipes located throughout the facility revealed the end caps were missing. NFPA 25, 6-2.1  Inspection of the 1st floor 2 hr fire wall (cinder block) located between the old main and the South corridors revealed 1/2" penetration in the wall. NFPA 101, 8.5.3.1	H 901			

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H 901	Continued From page 2  Inspection of the 1st floor 2 hr fire wall (cinder block) located in the in-patient nursing mangers corridor revealed the top of the sprinkler pipe was not sealed. The 1/2" and 6" metal conduits ends were not sealed. NFPA 101, 8.5.3.1  Inspection of the roof top heliport revealed the 2 exit signs were not illuminated and legible. NFPA 101, 7.10.5.1 and NFPA 101, 7.10.3.1  Inspection of cardiac rehab revealed the sprinklers were dirty (lint). NFPA 25, 5.2.1.1.1  Inspection of the education department revealed the sprinklers were dirty (lint). NFPA 25, 5.2.1.1.1  Inspection of the mechanical rooms located throughout the facility revealed portions of the ceilings deck support beams were missing the 2 hr fire coating. NFPA 220  Inspection of equipment room 9 revealed the 2 hr cinder block fire wall had a 2" x 4" penetration. NFPA 101, 8.5.3.1  Inspection of the 2nd floor West corridor (exit) fire door revealed the door did not close within the door frame. NFPA 80, 15.1.4  Inspection of the 2nd floors' main equipment room's fire wall ((2) 5/8" drywall) revealed the 2" metal conduit end was not sealed. NFPA 101, 8.5.3.1  Inspection of the OB cat walk exit canopy revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2	H 901			

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H 901	<p>Continued From page 3</p> <p>Inspection of the ER ambulance and ER main entrance canopies revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2</p> <p>Inspection of the surgery oxygen storage room revealed 2 unsecured oxygen cylinders. NFPA 7.1.3.4</p> <p>Inspection of the 1st floor North exit stairwell revealed the fire wall had a 1/8" crack down the wall. NFPA 101, 8.5.3.1</p> <p>Inspection of the 1st floor West supply (319) and in-patient rehab supply rooms revealed no smoke detectors installed in the rooms. NFPA 101, 9.6.2.10.1</p> <p>Inspection of equipment room 1 revealed 3 electrical j-boxes with no covers installed. NFPA 70, 314.28(3)(c)</p> <p>Inspection of equipment room 1 revealed the heating and cooling duct flange located at the ceiling deck had a 1/2" penetration. NFPA 101, 8.5.3.1</p> <p>Inspection of the main boiler room revealed 2 hr cinder block fire wall had a 3" x 3" penetration. The 5" metal pipe was not sealed at the fire wall. NFPA 101, 8.5.3.1</p> <p>Inspection of equipment rooms 10 and 11 revealed the sprinklers were corroded. The sprinklers must be replaced not cleaned. NFPA 25, 5.2.1.1.2</p> <p>Inspection of the kitchen revealed no C class portable fire extinguisher installed. NFPA 10, 4.1</p>	H 901			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP53129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED  06/04/2008
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H 901	Continued From page 4  Inspection of the kitchen revealed the sprinklers were dirty. NFPA 25, 5.2.1.1.2  Observation of the records revealed no biannual sensitivity test were conducted on the smoke detectors. NFPA 72, 10.4.3.2.2  Observation of the records revealed the 5 year sprinkler obstruction investigation was overdue. NFPA 25, 13.2.1	H 901			



May 31, 2013

John Marshall  
CEO  
Horizon Medical Center  
111 Highway 70 East  
Dickson, TN 37055

Joint Commission ID #: 7826  
Accreditation Activity: Unannounced Full  
Event  
Accreditation Activity Completed:  
05/31/2013

Dear Mr. Marshall:

Thank you for selecting The Joint Commission to conduct your recent Accreditation survey.

At The Joint Commission we strive to 'live' our mission.

*'To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.'*

As you know, Joint Commission standards go beyond just the 'basics' of state and federal regulations, and set consistently high expectations for quality and safety. We recognize that successfully meeting these standards is not an easy task, and doing so deserves special recognition from The Joint Commission, your Board and staff, your community, and especially your patients and their families.

The report we left onsite is designed to help focus on areas of further improvement, in the spirit of helping our organizations continuously improve.

Thank you for choosing The Joint Commission as your accreditor and committing to continued improvements in patient care quality and safety. We are honored to assist you in your mission.

Best wishes for your continued success.

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations



Horizon Medical Center  
111 Highway 70 East  
Dickson, TN 37055

**Organization Identification Number: 7826**

**Program(s)**  
Hospital Accreditation

**Survey Date(s)**  
05/29/2013-05/31/2013

### **Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.  
You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

## The Joint Commission Summary of Findings

**Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	MM.04.01.01	EP13

**Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	LS.02.01.10	EP3,EP5
	LS.02.01.30	EP11
	RC.01.01.01	EP19

**The Joint Commission  
Summary of CMS Findings**

**CoP:** §482.24      **Tag:** A-0431      **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

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**CoP:** §482.41      **Tag:** A-0700      **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP3, EP5, LS.02.01.30/EP11	Standard

# The Joint Commission Findings

**Chapter:** Life Safety  
**Program:** Hospital Accreditation  
**Standard:** LS.02.01.10

ESC 60 days

**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

3. Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)



**Scoring**

**Category :** A  
**Score :** Insufficient Compliance

5. Doors required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8 inch wide, and undercuts are no larger than 3/4 inch. (See also LS.02.01.30, EP 2; LS.02.01.34, EP 2) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1, 8.2.3.2.1 and NFPA 80-1999: 2-4.4.3, 2-3.1.7, and 1-11.4)



**Scoring**

**Category :** C  
**Score :** Insufficient Compliance

**Observation(s):**

## The Joint Commission Findings

### EP 3

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that on the 3rd floor the Heart Center was defined as being in a healthcare occupancy. The walls surrounding the Heart Center were rated as 1 hour fire walls instead of the required 2 hour rated fire walls. Healthcare occupancies are required to be separated from business occupancies by walls rated at least 2 hours. Also on the 3rd floor two of the three stairwells exited from the healthcare occupancy through stairwells located in business occupancies. Exits from healthcare occupancy through business occupancy is not permitted.

On the 2nd level one of the exits from the healthcare occupancy was through a stairwell located in the west pavilion which was rated as a business occupancy. The west pavilion was separated from the healthcare occupancy by a 2 hour rated fire wall, however, the stairwell was located about 10 feet beyond the 2 hour rated fire wall within the business occupancy. Exits from healthcare occupancy through business occupancy is not permitted.

On the 1st level an exit sign directed occupants to exit through the 2 sets of 90 minute rated double doors at the 2 hour fire wall separation from the laboratory/radiology corridor into the west pavilion. The west pavilion was classified as a business occupancy and the the laboratory/radiology corridor was within the healthcare occupancy. Exits from healthcare occupancy through business occupancy is not permitted.

### EP 5

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that on the 1st floor in the corridor near the ICU entrance, 1 of the 2 fire rated doors in the 2 hour separation did not have a fire rating label installed on the door. The door did have a label, however, the label did not rate the door. The label had the following verbiage: "This door is similar to a labeled fire retardant door in all construction features-But does not bear the label because of size".

Observed in Building Tour at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that on the 1st floor at the 2 hour separation in the lobby of the East Pavilion, 1 of the 2 fire rated doors did

## The Joint Commission Findings

not have a working self-closing device. The self-closing device had been disconnected and did not close the door.

Observed in Building Tour at Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that on the 1st floor at the 2 hour separation into the emergency department overflow area, the fire doors did not close completely. One of the doors was rubbing on the other door and did not completely close and latch.

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**Chapter:** Life Safety

**Program:** Hospital Accreditation

**Standard:** LS.02.01.30

ESC 60 days

**Standard Text:** The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.



Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

**Scoring**

**Category :** C

**Score :** Partial Compliance

**Observation(s):**

## The Joint Commission Findings

### EP 11

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that on the 3rd level the double doors at the entrance to the Heart Center suite did not have positive latching hardware. The area was sprinklered but the doors to the suite are considered to be corridor doors and all corridor doors are to be fitted with positive latching hardware.

Observed in Building Tour at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During the life safety building tour and validated in a discussion with the plant operations manager, the surveyor noted that inside of the surgery department the door to the female locker room had 2 holes. The holes in the door did not resist the passage of smoke.

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**Chapter:** Medication Management  
**Program:** Hospital Accreditation  
**Standard:** MM.04.01.01  
**Standard Text:** Medication orders are clear and accurate.  
**Primary Priority Focus Area:** Medication Management  
**Element(s) of Performance:**

13. The hospital implements its policies for medication orders.



### Scoring

**Category :** C  
**Score :** Partial Compliance

### Observation(s):

#### EP 13

Observed in Tracer Activities at Horizon Medical Center (111 Highway 70 East, Dickson, TN) site. Organization policies require that a pharmacist clarify all occurrences of therapeutic duplication. While tracing a patient, it was noted that a practitioner ordered two medications for the same indication, but the orders were not clarified before the medications were dispensed.

Observed in Tracer Activities at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site. During tracer activity, it was noted that a practitioner ordered multiple medications for the same indications without guidelines as to which to use first. The orders were not clarified before dispensing as required by organization policy.

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# The Joint Commission Findings

**Chapter:** Record of Care, Treatment, and Services  
**Program:** Hospital Accreditation  
**Standard:** RC.01.01.01

ESC 60 days

**Standard Text:** The hospital maintains complete and accurate medical records for each individual patient.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.



**Scoring**

**Category :** C  
**Score :** Insufficient Compliance

**Observation(s):**

EP 19

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Natchez Imaging and Cancer Center (2371 Highway 46, Dickson, TN) site for the Hospital deemed service.

While reviewing a medical record at the outpatient Cancer Center, it was noted that the physician's order was not timed.

Observed in Individual Tracer at Natchez Imaging and Cancer Center (2371 Highway 46, Dickson, TN) site for the Hospital deemed service.

In the same record reviewed at the Cancer Center, the nurses admission assessment was dated but not timed.

Observed in Individual Tracer at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

The post-anesthesia evaluation reviewed in the record of a patient who had undergone a cesarean section was not timed.

Observed in Tracer Activities at TriStar Horizon Medical Center (111 Highway 70 East, Dickson, TN) site for the Hospital deemed service.

During tracer activity, it was noted that a practitioner countersigned two entries by a PA, but did not time or date his countersignature.

## **Miscellaneous Information**

## Original Investigation

# Association Between Transient Newborn Hypoglycemia and Fourth-Grade Achievement Test Proficiency

## A Population-Based Study

Jeffrey R. Kaiser, MD, MA; Shasha Bai, PhD; Neal Gibson, PhD; Greg Holland, PhD; Tsai Mei Lin, MS; Christopher J. Swearingen, PhD; Jennifer K. Mehl, MD; Nahed O. ElHassan, MD

**IMPORTANCE** Prolonged neonatal hypoglycemia is associated with poor long-term neurocognitive function. However, little is known about an association between early transient newborn hypoglycemia and academic achievement.

**OBJECTIVE** To determine if early (within the first 3 hours of life) transient hypoglycemia (a single initial low glucose concentration, followed by a second value above a cutoff) is associated with subsequent poor academic performance.

**DESIGN, SETTING, AND PARTICIPANTS** A retrospective population-based cohort study of all infants born between January 1, 1998, and December 31, 1998, at the University of Arkansas for Medical Sciences who had at least 1 recorded glucose concentration (a universal newborn glucose screening policy was in effect) was conducted. Medical record data from newborns with normoglycemia or transient hypoglycemia were matched with their student achievement test scores in 2008 from the Arkansas Department of Education and anonymized. Logistic regression models were developed to evaluate the association between transient hypoglycemia and school-age achievement test proficiency based on perinatal factors. Common hypoglycemia cutoffs of a glucose level less than 35 mg/dL (primary) and less than 40 and 45 mg/dL (secondary) were investigated. All 1943 normoglycemic and transiently hypoglycemic infants (23-42 weeks' gestation) were eligible for inclusion in the study. Infants with prolonged hypoglycemia, congenital anomalies, or chromosomal abnormalities were excluded from the study.

### EXPOSURE Hypoglycemia as a newborn.


**MAIN OUTCOMES AND MEASURES** The primary outcome was proficiency on fourth-grade literacy and mathematics achievement tests at age 10 years. We hypothesized a priori that newborns with early transient hypoglycemia would be less proficient on fourth-grade achievement tests compared with normoglycemic newborns.

**RESULTS** Perinatal data were matched with fourth-grade achievement test scores in 1395 newborn-student pairs (71.8%). Transient hypoglycemia (glucose level <35, <40, and <45 mg/dL) was observed in 6.4% (89 of 1395), 10.3% (143 of 1395), and 19.3% (269 of 1395) of newborns, respectively. After controlling for gestational age group, race, sex, multifetal gestation, insurance status, maternal educational level and socioeconomic status, and gravidity, transient hypoglycemia was associated with decreased probability of proficiency on literacy and mathematics fourth-grade achievement tests. For the 3 hypoglycemia cutoffs, the adjusted odds ratios (95% CIs) for literacy were 0.49 (0.28-0.83), 0.43 (0.28-0.67), and 0.62 (0.45-0.85), respectively, and the adjusted odds ratios (95% CIs) for mathematics were 0.49 (0.29-0.82), 0.51 (0.34-0.78), and 0.78 (0.57-1.08), respectively.

**CONCLUSIONS AND RELEVANCE** Early transient newborn hypoglycemia was associated with lower achievement test scores at age 10 years. Given that our findings are serious and contrary to expert opinion, the results need to be validated in other populations before universal newborn glucose screening should be adopted.

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 Editorial

 Supplemental content at  
jamapediatrics.com

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At birth, the continuous utero-placental-umbilical infusion of glucose ends and reaches the lowest values during the first 1 to 2 hours,<sup>1</sup> stimulating counterregulatory mechanisms and promoting successful glucose homeostasis in healthy newborns. This occurrence is critical because the newborn brain principally uses glucose for energy and prolonged hypoglycemia has been associated with poor long-term neurodevelopment and neurocognition.<sup>2-10</sup> Nevertheless, little is known about whether early transient hypoglycemia, frequently considered to be a normal physiological phenomenon with no serious sequelae,<sup>1,11</sup> is associated with cognitive impairment.<sup>3,4,8,12-14</sup>

Most newborn hypoglycemia outcome studies have limited generalizability because of the evaluation of at-risk infants only, a lack of nonhypoglycemic control subjects, and small sample sizes (including only symptomatic newborns, although hypoglycemic signs are nonspecific).<sup>15</sup> As identified in the review by Boluyt et al,<sup>15</sup> hypoglycemia cohort studies<sup>2,4-10,14,15,17</sup> during the first week of life have reported follow-up findings at a mean age of 2.5 years. More recently, Tin and colleagues<sup>18</sup> reported on the 15-year follow-up of preterm newborns with recurrent hypoglycemia and found no difference in their IQs compared with controls. However, that study and most other hypoglycemic outcome studies (except for the study by Lucas et al<sup>8</sup>) failed to control for maternal educational level and socioeconomic status, factors that are highly associated with childhood neurocognitive outcome and educational performance.<sup>18-23</sup>

The American Academy of Pediatrics 2011 report on glucose homeostasis acknowledged that screening and management of newborn hypoglycemia is “a controversial issue for which evidence is lacking but guidance is needed.”<sup>11(p575)</sup> These guidelines are based on expert opinion and lack support from high-quality long-term follow-up studies.<sup>11,13,24</sup> Therefore, it remains to be determined whether transient newborn hypoglycemia (defined as a single initial low glucose concentration, followed by a second concentration above a cutoff) is associated with subsequent impaired scholastic performance. To address this knowledge gap, we compared initial newborn glucose concentrations in 1998 from the universal glucose screening database available at the University of Arkansas for Medical Sciences (UAMS) with their 2008 matched student achievement test scores.<sup>8,13</sup> We abstracted perinatal and maternal factors evaluated in earlier neonatal hypoglycemia studies and included maternal educational level and socioeconomic status. Our objective was to evaluate an association between transient newborn hypoglycemia and proficiency on school-age achievement tests, which are real-world assessments that predict high school graduation, college attendance, and long-term adult success.<sup>25-28</sup> We considered the hypoglycemia cutoffs of a glucose level less than 35 mg/dL (primary) and less than 40 and 45 mg/dL (secondary) to define hypoglycemia<sup>8,13</sup> and hypothesized a priori that newborns with early transient hypoglycemia would be less proficient on fourth-grade achievement tests compared with normoglycemic newborns with similar perinatal factors. (To convert glucose concentration from mg/dL to millimoles per liter, multiply by 0.0555.)

### At a Glance

- The study objective was to determine if transient newborn hypoglycemia is associated with poor academic performance.
- Transient newborn hypoglycemia (glucose level <35, <40, and <45 mg/dL) was observed in 6.4%, 10.3%, and 19.3% of infants, respectively.
- After controlling for multiple perinatal factors, early transient hypoglycemia was associated with decreased probability of proficiency on literacy and mathematics fourth-grade achievement tests.
- Given that the findings of our study are serious and contrary to expert opinion, the results need to be validated in other populations before universal newborn glucose screening should be adopted.

## Methods

### Participants

Included in the study were all infants (23-42 weeks' gestation) born at the UAMS in 1998 who had at least 1 recorded glucose concentration and who survived to hospital discharge without major congenital anomalies (including microcephaly) or chromosomal abnormalities. Thirty-four infants with prolonged hypoglycemia (having at least the first 2 glucose concentrations under a cutoff) were excluded. The study received UAMS institutional review board approval. In addition, a Health Insurance Portability and Accountability Act of 1996 waiver and an Arkansas Department of Education Family Educational Rights and Privacy Act waiver were obtained.

### Universal Newborn Glucose Screening Policy

The UAMS universal newborn glucose screening policy was to obtain an early glucose concentration from all newborns, and compliance exceeded 99%. Plasma glucose concentrations (including collection, laboratory receipt, and verification date and times) were available from the laboratory database and were determined in the pediatric laboratory within the neonatal intensive care unit using the glucose oxidase method (Glucose 2 Analyzer; Beckman Coulter). The pediatric laboratory met approval standards of the Clinical Laboratory Improvement Act, and the equipment was routinely checked to ensure quality control. While there were no written hypoglycemia treatment guidelines in 1998, generally newborns with initial (1-3 hours after birth) glucose concentrations of 35 mg/dL or less received intravenous dextrose or an early feeding. Follow-up values for hypoglycemic infants were obtained approximately 1 hour after the initial value.

### Definitions and Data Collection

Four gestational age groups were defined. These included (1) full term ( $\geq 37$  to 42 weeks), (2) late preterm ( $\geq 34$  to <37 weeks), (3) preterm ( $\geq 28$  to <34 weeks), and (4) extremely low gestational age (<28 weeks) newborns. Gestational age from medical records was uniformly recorded (eg, 26 weeks' gestation would apply to newborns identified as “26+ weeks” or “26 weeks and 0-6 days”).

Data were retrieved from the 1998 UAMS medical records and from the Arkansas Department of Health birth certificate and Arkansas Department of Education databases. Data abstracted from the newborn record included name, birth date and time, birth weight, estimated gestational age, size for gestational age, race, sex, Apgar scores, singleton or multiple status, and the presence of polycythemia (hematocrit  $\geq 65\%$ ). Data abstracted from the mother's record included name, age, insurance status, educational level, gravidity, prenatal care, medical conditions, delivery route, pregnancy-associated and obstetrical conditions, and history of smoking or substance abuse. Data were stored in Research Electronic Data Capture (REDCap)<sup>29</sup> (1UL1RRO29884) hosted at the UAMS Translational Research Institute.

### Matching Newborn and Student Data

Newborn names and birth dates from medical records and Social Security numbers from the Arkansas Department of Health birth certificate database were compared with student names, birth dates, and Social Security numbers from the Arkansas Department of Education database by one of us (G.H.) who is an expert in identity resolution and matching for longitudinal education data.<sup>30</sup> Positive identification was defined as an exact match of the Social Security number or (if a Social Security number was not available) a newborn's name and birth date with those of a student's. Multiple techniques were used to increase the number of positive identifications for newborn-student pairs while limiting false positives by using frequency-based confidences.<sup>30</sup> If positive identification could not be made with the newborn's name, birth date, or Social Security number, a combination of the newborn's information and the mother's name was used. If unsuccessful, no further matching attempts were made.

To protect confidentiality, data were securely transmitted to the Arkansas Department of Health, where Social Security numbers were added. This new file was then securely transmitted to the Arkansas Department of Education, where achievement test results were added and anonymized. This file was transmitted back to us as an encrypted file. The final data set included UAMS-born participants who were successfully matched with their student achievement test scores.

### Achievement Tests

The Benchmark Examination was developed to assess student competencies in literacy and mathematics according to Arkansas education standards for each grade, and all Arkansas public school students in grades 3 through 8 have been mandated to take the tests since 1997 (<http://www.ArkansasEd.org>). Scores were designated categorically as advanced, proficient, basic, or below basic based on scaled scores of 0 to 1000, assigned according to the percentage of correct answers. Proficient or advanced scores (proficient) represent performance at or above grade level, while basic and below basic scores (nonproficient) represent performance below grade level. Children with significant cognitive disabilities do not take the Benchmark Examination and were not included in the analyses.

### Primary Outcomes

The primary outcome variables were proficiency (yes or no) on fourth-grade literacy and mathematics achievement tests. We chose fourth-grade (age 10 years) achievement test proficiency as our primary outcome of interest because children were first exposed to the Benchmark Examination in third grade and would be expected to be more familiar with achievement test procedures. In addition, other studies<sup>31-33</sup> have linked perinatal characteristics with school-age cognitive, academic, and school performance at ages 8 to 11 years.

### Statistical Analysis

To compare characteristics of hypoglycemic and normoglycemic newborns, we used a 2-sample *t* test with unequal variances for continuous variables, rank sum test for count variables, and Fisher exact test for categorical variables for the 3 hypoglycemic cutoffs of a glucose level less than 35 mg/dL (primary) and less than 40 and 45 mg/dL (secondary). The odds ratios (ORs) and 95% CIs from the univariate logistic regression for potential independent predictors of achievement test proficiency were then determined.

Variables with  $P < .10$  from the univariate analysis were considered as possible covariates for the multivariable logistic regression models. A stepwise backward elimination method was used in which the least significant variable was removed at each step until the remaining variables were significant ( $P < .05$ ) (STATA 13; StataCorp LP). Collinearity was evaluated using a variance inflation factor. Adjusted ORs and 95% CIs for variables in the final logistic regression models for literacy and mathematics proficiency by the 3 cutoffs were then determined.

## Results

We matched 1395 of 1943 newborns (71.8%) having normoglycemia or transient hypoglycemia with their achievement test scores. Characteristics of the study sample by hypoglycemic and normoglycemic status using each of the hypoglycemia cutoffs are listed in Table 1 and Table 2. The mean (SD) birth weight and estimated gestational age of the matched cohort were 2881 (855) g and 36.8 (3.8) weeks, respectively. Most newborns were full term and late preterm. Overall, 94.7% (1321 of 1395) of newborns were of black or white race, and 50.3% (702 of 1395) were male. Five-minute Apgar scores less than 7 were present in 6.4% (88 of 1395) of infants. In addition, 5.9% (82 of 1395) of infants were from multifetal gestations. As is typical of a university hospital population, 81.5% (1137 of 1395) of families had Medicaid or no insurance, and 25.4% (335 of 1319) of mothers had an educational level beyond high school. The mothers of 4.9% (68 of 1395) of newborns had diabetes mellitus. The cesarean section rate was 31.0% (432 of 1395). Most characteristics of newborns unmatched to achievement test scores were equivalent to those of matched infants<sup>34,35</sup> except that there were fewer black infants and fewer newborns with Medicaid in the unmatched cohort (eTable 1 in the Supplement).

In general, hypoglycemic infants were smaller, less mature, less commonly full term, and more commonly from mul-

**Table 1. Newborn Characteristics of the Study Sample by Hypoglycemia Cutoffs (Glucose Level <35, <40, and <45 mg/dL)**

Variable	<35 mg/dL Hypoglycemic (n = 89)	Normoglycemic (n = 1306)	<40 mg/dL Hypoglycemic (n = 143)	Normoglycemic (n = 1252)	<45 mg/dL Hypoglycemic (n = 269)	Normoglycemic (n = 1126)
<b>Newborn Characteristics</b>						
Birth weight, mean (SD), g	2537 (951)	2904 (843)	2576 (996)	2916 (830)	2675 (966)	2931 (818)
Estimated gestational age, mean (SD), wk	34.6 (3.7)	37.0 (3.7)	34.8 (3.9)	37.1 (3.7)	35.4 (4.1)	37.2 (3.6)
Gestational age group, No. (%)						
Full term	33 (37.1)	922 (70.6)	56 (39.2)	899 (71.8)	134 (49.8)	821 (72.9)
Late preterm	19 (21.3)	198 (15.2)	33 (23.1)	184 (14.7)	59 (21.9)	158 (14.0)
Preterm	34 (38.2)	131 (10.0)	48 (33.6)	117 (9.3)	61 (22.7)	104 (9.2)
Extremely low gestational age newborn	3 (3.4)	55 (4.2)	6 (4.2)	52 (4.2)	15 (5.6)	43 (3.8)
Size at birth, No. (%)						
Appropriate for gestational age	66 (74.2)	1048 (80.2)	102 (71.3)	1012 (80.8)	202 (75.1)	912 (81.0)
Large for gestational age	8 (9.0)	82 (6.3)	14 (9.8)	76 (6.1)	24 (8.9)	66 (5.9)
Small for gestational age	15 (16.9)	176 (13.5)	27 (18.9)	164 (13.1)	43 (16.0)	148 (13.1)
Race, No. (%)						
Black	38 (42.7)	615 (47.1)	62 (43.4)	591 (47.2)	122 (45.4)	531 (47.2)
White	44 (49.4)	624 (47.8)	71 (49.7)	597 (47.7)	127 (47.2)	541 (48.0)
Other	7 (7.9)	67 (5.1)	10 (7.0)	64 (5.1)	20 (7.4)	54 (4.8)
Male sex, No. (%)	39 (43.8)	663 (50.8)	69 (48.3)	633 (50.6)	133 (49.4)	569 (50.5)
1-min Apgar score						
Median (IQR)	8 (7-9)	8 (7-9)	8 (7-9)	8 (7-9)	8 (7-9)	8 (7-9)
Score <7, No. (%)	18 (20.2)	281 (21.5)	34 (23.8)	265 (21.2)	65 (24.2)	234 (20.8)
5-min Apgar score						
Median (IQR)	9 (8-9)	9 (8-9)	9 (8-9)	9 (8-9)	9 (8-9)	9 (8-9)
Score <7, No. (%)	5 (5.6)	83 (6.4)	10 (7.0)	78 (6.2)	18 (6.7)	70 (6.2)
Multifetal gestation, No. (%)	13 (14.6)	69 (5.3)	18 (12.6)	64 (5.1)	26 (9.7)	56 (5.0)
Polycythemia, No. (%)	4 (4.5)	22 (1.7)	7 (4.9)	19 (1.5)	10 (3.7)	16 (1.4)

SI conversion factor: To convert glucose concentration to millimoles per liter, multiply by 0.0555.

tifetal gestations. In addition, they were more frequently polycythemic, infants of mothers with diabetes mellitus, and born to mothers with pregnancy-related conditions and were less likely to have been delivered vaginally. These results are summarized in Table 1 and Table 2.

#### Initial Glucose Concentration Distribution

Among 1395 matched newborns, the mean (SD) initial glucose concentration was 59.5 (19.9) mg/dL (range, 13-231 mg/dL), and the median (interquartile range) was 57 mg/dL (48-68 mg/dL) (Figure 1). The median (interquartile range) time to specimen collection was 89 minutes (68-115 minutes) after birth, and specimen results were reported within 25 minutes after collection. This short turnaround time was because of staffing with dedicated phlebotomists and the presence of a pediatric laboratory within the neonatal intensive care unit. Transient hypoglycemia occurred in 6.4% (89 of 1395), 10.3% (143 of 1395), and 19.3% (269 of 1395) of newborns with cutoffs of a glucose level less than 35, 40, and 45 mg/dL, respectively. For transiently hypoglycemic newborns, follow-up glucose concentrations were obtained at a median (interquartile range) of 70 minutes (22-156 minutes).

#### Primary Unadjusted Outcomes for Hypoglycemic and Normoglycemic Newborns

The mean (SD) fourth-grade literacy test score and the proficiency rate were 544 (165) and 32% for hypoglycemic (<35 mg/dL) newborns vs 583 (195) and 57% for normoglycemic newborns (≥35 mg/dL). The mean (SD) mathematics test score and the proficiency rate were 562 (94) and 46% for hypoglycemic newborns vs 589 (104) and 64% for normoglycemic newborns. Test scores for hypoglycemic and normoglycemic newborns were similar among the 3 cutoffs (Figure 2).

#### Logistic Regression Models

The final logistic regression models for literacy and mathematics contained the same covariates irrespective of the hypoglycemic cutoff used (Table 3). Because birth weight and gestational age were highly collinear, we used only one of these covariates (the categorical classification of gestational age groups) in the final models. Collinearity issues were not found between the remaining covariates in the final models.

Transient hypoglycemia was significantly associated with decreased probability of proficiency on literacy achievement tests (adjusted ORs, 0.49, 0.43, and 0.62) and on mathemat-

Table 2. Maternal Characteristics of the Study Sample by Hypoglycemia Cutoffs (Glucose Level &lt;35, &lt;40, and &lt;45 mg/dL)

Variable	<35 mg/dL		<40 mg/dL		<45 mg/dL	
	Hypoglycemic (n = 89)	Normoglycemic (n = 1306)	Hypoglycemic (n = 143)	Normoglycemic (n = 1252)	Hypoglycemic (n = 269)	Normoglycemic (n = 1126)
<b>Maternal Characteristics</b>						
Age, mean (SD), y	24.7 (6.6)	23.9 (6.1)	24.6 (6.9)	23.9 (6.0)	24.1 (6.6)	23.9 (6.0)
Insurance, No. (%)						
Medicaid	69 (77.5)	984 (75.3)	110 (76.9)	943 (75.3)	204 (75.8)	849 (75.4)
Private	17 (19.1)	241 (18.5)	27 (18.9)	231 (18.5)	49 (18.2)	209 (18.6)
Other	3 (3.4)	81 (6.2)	6 (4.2)	78 (6.2)	16 (5.9)	68 (6.0)
Educational level, No. (%) <sup>a</sup>	(n = 86)	(n = 1233)	(n = 136)	(n = 1183)	(n = 258)	(n = 1061)
<High school	35 (40.7)	402 (32.6)	54 (39.7)	383 (32.4)	103 (39.9)	334 (31.5)
High school graduate	29 (33.7)	518 (42.0)	49 (36.0)	498 (42.1)	93 (36.0)	454 (42.8)
>High school	22 (25.6)	313 (25.4)	33 (24.3)	302 (25.5)	62 (24.0)	273 (25.7)
Gravidity		(n = 1303)		(n = 1249)		(n = 1123)
Median (IQR)	2 (2-3)	2 (1-3)	2 (2-3)	2 (1-3)	2 (1-3)	2 (1-3)
1, No. (%)	22 (24.7)	445 (34.2)	34 (23.8)	433 (34.7)	78 (29.0)	389 (34.6)
2-3, No. (%)	47 (52.8)	610 (46.8)	78 (54.5)	579 (46.4)	137 (50.9)	520 (46.3)
>3, No. (%)	20 (22.5)	248 (19.0)	31 (21.7)	237 (19.0)	54 (20.1)	214 (19.1)
No prenatal care, No. (%)	3 (3.4)	36 (2.8)	7 (4.9)	32 (2.6)	10 (3.7)	29 (2.6)
Diabetes mellitus, No. (%)						
Nondiabetic	77 (86.5)	1250 (95.7)	127 (88.8)	1200 (95.8)	248 (92.2)	1079 (95.8)
Prepregnancy	8 (9.0)	25 (1.9)	11 (7.7)	22 (1.8)	14 (5.2)	19 (1.7)
Gestational	4 (4.5)	31 (2.4)	5 (3.5)	30 (2.4)	7 (2.6)	28 (2.5)
Vaginal delivery, No. (%)	49 (55.1)	914 (70.0)	79 (55.2)	884 (70.6)	165 (61.3)	798 (70.9)
Pregnancy-induced hypertension, No. (%)	26 (29.2)	249 (19.1)	39 (27.3)	236 (18.8)	66 (24.5)	209 (18.6)
Premature rupture of the membrane, No. (%)	24 (27.0)	166 (12.7)	33 (23.1)	157 (12.5)	58 (21.6)	132 (11.7)
Chorioamnionitis, No. (%)	9 (10.1)	54 (4.1)	10 (7.0)	53 (4.2)	15 (5.6)	48 (4.3)
Meconium, No. (%)	3 (3.4)	132 (10.1)	4 (2.8)	131 (10.5)	16 (5.9)	119 (10.6)
Smoking, No. (%)	6 (6.7)	26 (2.0)	9 (6.3)	23 (1.8)	13 (4.8)	19 (1.7)
Substance abuse, No. (%)	3 (3.4)	27 (2.1)	5 (3.5)	25 (2.0)	7 (2.6)	23 (2.0)

SI conversion factor: To convert glucose concentration to millimoles per liter, multiply by 0.0555.

<sup>a</sup> Data for maternal educational level were available for 94.6% (1319 of 1395) of newborns.

ics achievement tests (adjusted ORs, 0.49, 0.51, and 0.78) for the 3 hypoglycemia cutoffs, respectively. Factors positively associated with increased probability of proficiency on achievement tests in all 6 models were female sex, singleton birth, full-term status, white and other race, private insurance, maternal educational level exceeding high school, and primiparous birth. The covariates had similar effect sizes in the independent literacy and mathematics models irrespective of the cutoff used. All logistic regression models fit the data adequately and demonstrated acceptable discrimination. When excluding the most premature and high-risk infants (extremely low-gestational-age newborns), similar associations were observed between transient hypoglycemia and achievement test performance compared with the whole study sample (eTable 2 in the Supplement).

## Discussion

Despite more than 50 years of neonatal hypoglycemia research, uncertainty remains about which newborns to

screen, whether transient hypoglycemia has untoward long-term effects, and what concentration or range of glucose concentrations should be used to define neonatal hypoglycemia, as well as about management strategies and the incidence of transient hypoglycemia. Moreover, a link between transient hypoglycemia and poor neurodevelopmental long-term outcome has been difficult to establish because recommendations for screening and managing hypoglycemia are largely empirical and not based on long-term follow-up studies or neurodevelopmental testing.<sup>11,13,24</sup> Most important, we found that early transient newborn hypoglycemia was not uncommon (6.4%, 10.3%, and 19.3% of newborns using cutoffs of <35, <40, and <45 mg/dL, respectively), and our observed incidences were consistent with but appropriately lower than the incidences from higher-risk populations.<sup>36</sup> By leveraging existing data and resources available in Arkansas, including the UAMS policy of universal newborn glucose screening, it was determined that most infants born at the UAMS remain in Arkansas and later attend public schools. Because of excellent working relationships with the Arkansas Department of Health and

Department of Education, we were well positioned to link early transient newborn hypoglycemia with achievement test performance. After controlling for multiple covariates and using several cutoffs to define hypoglycemia, we observed that transient hypoglycemia in a heterogeneous cohort of newborns born at a university hospital was associated with lower fourth-grade achievement test scores, real-world assessments that predict educational and economic success.<sup>25-28</sup>

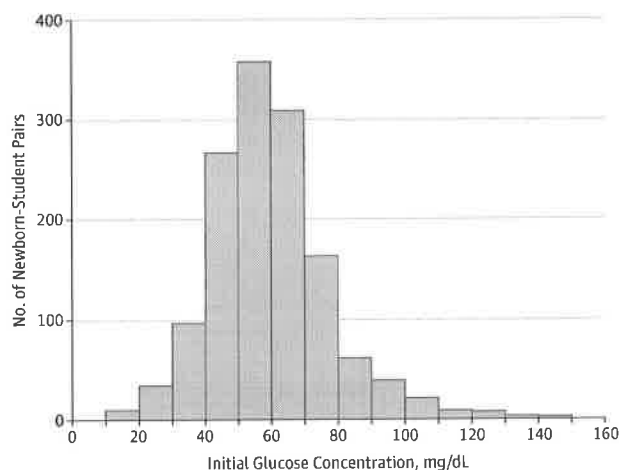
Consistent with previous studies, we observed that newborns with private insurance (a proxy for socioeconomic status<sup>22</sup>) were more proficient on fourth-grade tests than new-

borns who had Medicaid or who were self-pay.<sup>19</sup> White race and female sex were associated with greater proficiency than black race and male sex.<sup>19,21</sup> Newborns whose mothers had more years of education had higher test scores. Newborns of primiparous women fared better than those who had siblings.<sup>20</sup> After controlling for multiple variables, we also found that maternal and obstetrical diagnoses were not associated with test proficiency.

Preschool-aged children with severe and prolonged hypoglycemia as newborns generally are neurodevelopmentally delayed.<sup>6</sup> In a large study by Lucas et al<sup>8</sup> of premature infants, recurrent moderate hypoglycemia was associated with developmental delay at age 18 months. In contrast, Tin and colleagues<sup>18</sup> replicated the study by Lucas et al<sup>8</sup> and reported no difference in IQs between adolescents who had recurrent hypoglycemia (glucose level  $\leq 45$  mg/dL) compared with matched controls. Despite an unparalleled 15-year follow-up, the study by Tin and colleagues<sup>18</sup> did not control for socioeconomic status or maternal educational level, factors known to be associated with childhood psychometric and academic performance.<sup>19-23</sup> Both the study by Lucas et al<sup>8</sup> and our study adjusted for socioeconomic status and maternal educational level and observed differences in neurodevelopmental and educational outcomes.

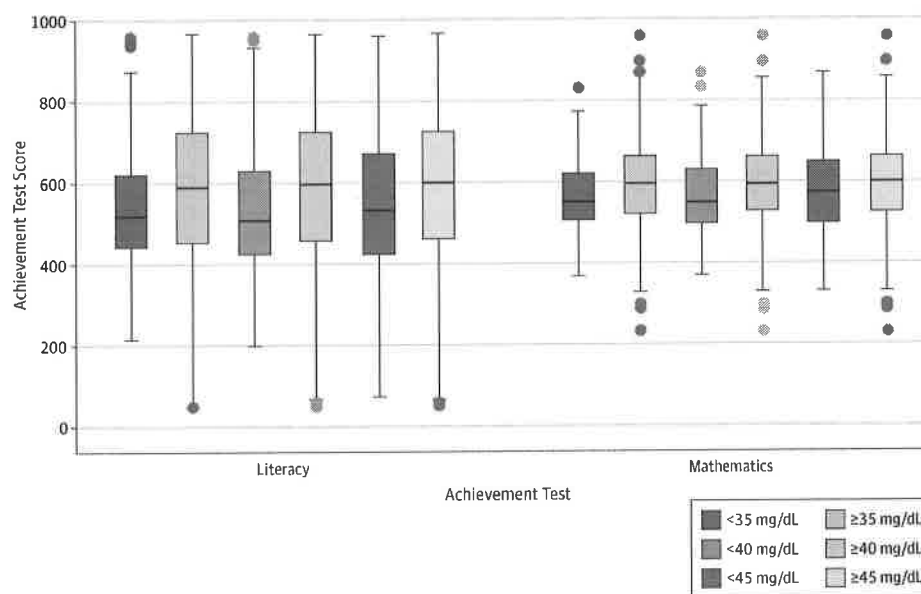
A study by Brand and colleagues,<sup>5</sup> considered to be of high quality by Boluyt et al,<sup>15</sup> evaluated the effects of transient hypoglycemia during the first day of life in a cohort of 75 healthy term large-for-gestational-age infants and detected no significant difference in neurodevelopment between children with and without hypoglycemia at age 4 years, although normoglycemic children performed significantly better on a reasoning subscale test. Brand and colleagues<sup>5</sup> did not adjust for socioeconomic status or maternal educational level and acknowledged in their discussion that the observed sugges-

**Figure 1. Initial Newborn Glucose Concentrations From 1395 Matched Newborn-Student Pairs**



To convert glucose concentration to millimoles per liter, multiply by 0.0555.

**Figure 2. Literacy and Mathematics Achievement Test Scores for Hypoglycemic and Normoglycemic Newborns by Hypoglycemia Cutoffs (Glucose Level  $<35$ ,  $<40$ , and  $<45$  mg/dL)**



Test scores are unadjusted. To convert glucose concentration to millimoles per liter, multiply by 0.0555.

**Table 3. Variables Associated With Literacy and Mathematics Achievement Test Proficiency by Hypoglycemia Cutoffs (Glucose Level <35, <40, and <45 mg/dL)<sup>a</sup>**

Variable	Adjusted Odds Ratio (95% CI)					
	Literacy			Mathematics		
	<35 mg/dL	<40 mg/dL	<45 mg/dL	<35 mg/dL	<40 mg/dL	<45 mg/dL
Hypoglycemia	0.49 (0.28-0.83)	0.43 (0.28-0.67)	0.62 (0.45-0.85)	0.49 (0.29-0.82)	0.51 (0.34-0.78)	0.78 (0.57-1.08)
<b>Gestational age group</b>						
Full term	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
Late preterm	0.85 (0.59-1.23)	0.88 (0.61-1.28)	0.88 (0.61-1.27)	0.86 (0.59-1.24)	0.88 (0.61-1.27)	0.86 (0.59-1.25)
Preterm	0.89 (0.59-1.35)	0.97 (0.63-1.48)	0.89 (0.59-1.35)	0.76 (0.50-1.16)	0.79 (0.52-1.21)	0.71 (0.47-1.08)
Extremely low gestational age newborn	0.55 (0.29-1.06)	0.57 (0.29-1.10)	0.59 (0.30-1.13)	0.22 (0.11-0.42)	0.22 (0.11-0.43)	0.22 (0.11-0.43)
<b>Race</b>						
Black	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
White	2.80 (2.15-3.65)	2.83 (2.17-3.69)	2.80 (2.15-3.65)	2.93 (2.24-3.84)	2.95 (2.26-3.87)	2.92 (2.23-3.82)
Other	4.04 (2.18-7.49)	4.02 (2.17-7.47)	4.05 (2.18-7.51)	2.63 (1.43-4.84)	2.59 (1.41-4.77)	2.58 (1.41-4.74)
Male sex	0.51 (0.40-0.66)	0.51 (0.40-0.66)	0.51 (0.40-0.66)	0.80 (0.62-1.04)	0.80 (0.62-1.04)	0.80 (0.62-1.04)
Multifetal gestation	0.51 (0.28-0.92)	0.50 (0.27-0.91)	0.49 (0.27-0.88)	0.60 (0.33-1.0)	0.59 (0.33-1.05)	0.58 (0.32-1.02)
<b>Insurance</b>						
Medicaid	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
Other	0.87 (0.51-1.50)	0.87 (0.51-1.51)	0.89 (0.52-1.53)	1.26 (0.72-2.22)	1.27 (0.72-2.24)	1.29 (0.74-2.27)
Private	1.94 (1.31-2.88)	1.94 (1.30-2.87)	1.94 (1.31-2.87)	2.03 (1.40-2.97)	2.02 (1.33-3.07)	2.03 (1.34-3.08)
<b>Maternal educational level</b>						
<High school	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
High school graduate	1.53 (1.14-2.05)	1.51 (1.12-2.03)	1.52 (1.13-2.05)	1.31 (0.98-1.77)	1.31 (0.97-1.76)	1.33 (0.99-1.79)
>High school	2.58 (1.78-3.73)	2.54 (1.76-3.68)	2.54 (1.76-3.67)	2.04 (1.39-2.94)	2.02 (1.39-2.94)	2.03 (1.39-2.95)
<b>Gravidity</b>						
1	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]
2-3	0.57 (0.42-0.76)	0.58 (0.43-0.77)	0.56 (0.42-0.75)	0.76 (0.56-1.02)	0.77 (0.57-1.03)	0.75 (0.55-1.00)
>3	0.38 (0.26-0.55)	0.39 (0.27-0.56)	0.38 (0.26-0.54)	0.48 (0.33-0.70)	0.49 (0.34-0.70)	0.47 (0.33-0.68)

SI conversion factor: To convert glucose concentration to millimoles per liter, multiply by 0.0555.

<sup>a</sup> Multivariable regression analysis.

tion of poorer outcomes in transiently hypoglycemic infants could have been significant with a larger sample size.<sup>5</sup> Compared with the study by Brand and colleagues,<sup>5</sup> our study had a much larger sample size, investigated a heterogeneous population of newborns instead of at-risk infants only, followed up newborns much longer, and controlled for maternal educational level and socioeconomic status.

There has been considerable debate about whether a single glucose concentration or an operational threshold should be used to define neonatal hypoglycemia and to guide interventions,<sup>13</sup> as well as about whether the same threshold is appropriate for all newborns. Plasma glucose concentrations of 18 to 47 mg/dL have been used in other studies<sup>24,37</sup> as cutoffs for defining hypoglycemia. In the study by Lucas et al,<sup>8</sup> the investigators statistically tested cutoffs of 9 to 72 mg/dL and found that a cutoff of 47 mg/dL (during the first 9 weeks of life) was most highly correlated with 18-month development. Instead of using post hoc analyses to find the most significant cutoff, we examined 3 glucose concentrations as possible conservative cutoffs for defining hypoglycemia based on clinical considerations and practices used by neonatologists in 1998.

This study has notable strengths that have real-world implications. These include the large sample size and the consideration of perinatal covariates, maternal educational level, and socioeconomic status. In addition, our study used several clinically relevant cutoffs and glucose concentrations from a universal glucose screening database rather than from at-risk infants only, as well as objective, valid, and blinded outcomes. Our primary outcomes at age 10 years exceeded the mean 2.5-year follow-up from most previous hypoglycemia cohort studies.<sup>2,4-8,10,14,16,17</sup>

However, there were some limitations to our study. We used retrospective observational data, and glucose concentrations were based on specimens collected at times that were at the discretion of bedside nurses. Glucose concentrations were evaluated only for the first 2 values, and we could not determine the duration of hypoglycemia or the minimal glucose concentration and their effects on test scores. Furthermore, hypoglycemia treatment strategies were not examined. In addition, we were able to match only 71.8% of newborns with their achievement tests. However, most characteristics were equivalent between matched and unmatched infants. The limitations of using existing data from medical records and state

birth certificate and student achievement test databases in a retrospective cohort study are far outweighed by the ability to make valid assessments about newborn glucose homeostasis based on our careful conservative matching techniques.<sup>30</sup> Information regarding signs of hypoglycemia were inconsistently available from medical records, and anecdotally most newborns with transient hypoglycemia were asymptomatic. We could not account for personal childhood characteristics (primary household language, disabilities, school absenteeism, etc) and diagnoses or for 10 years of environmental influences and nutrition, similar to previously performed hypoglycemia cohort follow-up studies. Barker et al<sup>38</sup> also found associations between fetal or infant parameters and adult disease and did not account for intervening influences. Given that so many factors not accounted for in this study could have affected fourth-grade test performance, the fact that at age 10 years we still observed differences in school performance between transiently hypoglycemic and normoglycemic newborns is noteworthy. Although this single-center study has limitations and its results may be most generalizable to university hospital populations, establishing associations between tran-

sient hypoglycemia and childhood achievement is important in informing future newborn hypoglycemia recommendations and may serve as preliminary data for a definitive prospective trial.

## Conclusions

Current guidelines recommend screening only in newborns with symptomatic hypoglycemia or those at risk of developing hypoglycemia.<sup>11,24</sup> Contrary to these expert opinion guidelines, our study suggests that early transient newborn hypoglycemia is associated with poorer academic performance at age 10 years. While our study did not prove that transient newborn hypoglycemia causes poor academic performance, we believe that the findings raise legitimate concerns that need to be further investigated in other newborn cohorts. Until our results are validated, however, universal newborn glucose screening should not be adopted. High-quality long-term follow-up studies are needed to direct future newborn hypoglycemia screening and treatment guidelines.

### ARTICLE INFORMATION

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**Author Contributions:** Dr Kaiser had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Study concept and design:** Kaiser.

**Acquisition, analysis, or interpretation of data:** All authors.

**Drafting of the manuscript:** All authors.

**Critical revision of the manuscript for important intellectual content:** All authors.

**Statistical analysis:** Bai, Swearingen.

**Study supervision:** Kaiser.

**Conflict of Interest Disclosures:** None reported.

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# TennCare Enrollment Report for August 2015

MCO	REGION	Total
AMERIGROUP COMMUNITY CARE		408,081
BLUECARE	East Tennessee	194,781
BLUECARE	Middle Tennessee	157,742
BLUECARE	West Tennessee	149,062
UnitedHealthcare Community Plan	East Tennessee	169,131
UnitedHealthcare Community Plan	Middle Tennessee	164,970
UnitedHealthcare Community Plan	West Tennessee	139,802
TENNCARE SELECT HIGH	All	50,631
TENNCARE SELECT LOW	All	13,138
PACE		279
Awaiting MCO assignment		40
<b>Grand Total</b>		<b>1,447,657</b>

COUNTY	Female					Male					Male Total	Grand Total	
	0 - 18	21 - 64			65 ->	Female Total	0 - 18	21 - 64					65 ->
		19 - 20	21 - 24	25 - 34				19 - 20	21 - 24	25 - 34			
ANDERSON	4,197	350	4,243	613	9,403	266	4,374	298	2,013	266	6,951	16,354	
BEDFORD	3,740	278	2,973	235	7,226	119	3,938	206	1,230	119	5,493	12,719	
BENTON	1,013	94	1,084	150	2,341	73	1,039	89	556	73	1,757	4,098	
BLEDSE	782	83	801	116	1,782	56	892	70	458	56	1,476	3,258	
BLOUNT	5,936	515	5,891	666	13,008	297	5,978	378	2,615	297	9,268	22,276	
BRADLEY	5,841	507	5,813	680	12,841	280	6,164	363	2,515	280	9,322	22,163	
CAMPBELL	2,879	323	3,698	665	7,565	383	3,065	215	2,009	383	5,672	13,237	
CANNON	743	68	796	130	1,737	52	790	70	370	52	1,282	3,019	
CARROLL	1,797	172	2,124	322	4,415	137	1,985	163	1,064	137	3,349	7,764	
CARTER	3,159	305	3,447	728	7,639	264	3,299	227	1,772	264	5,562	13,201	
CHEATHAM	1,957	184	1,885	159	4,185	85	2,075	154	865	85	3,179	7,364	
CHESTER	1,046	91	1,022	147	2,306	67	1,075	68	428	67	1,638	3,944	
CLAIBORNE	2,053	217	2,457	554	5,281	262	2,180	177	1,451	262	4,070	9,351	
CLAY	545	42	541	116	1,244	76	555	35	344	76	1,010	2,254	
COCKE	2,765	256	3,052	459	6,532	215	2,885	184	1,686	215	4,970	11,502	
COFFEE	3,592	331	3,485	386	7,794	172	3,651	233	1,532	172	5,588	13,382	
CROCKETT	1,090	84	953	204	2,331	80	1,052	67	456	80	1,655	3,986	
CUMBERLAND	3,228	287	3,199	499	7,213	241	3,377	244	1,558	241	5,420	12,633	
DAVIDSON	41,991	2,723	35,764	3,377	83,855	1,670	43,270	2,206	14,478	1,670	61,624	145,479	
DECATUR	641	75	723	192	1,631	64	735	49	400	64	1,248	2,879	
DEKALB	1,352	119	1,311	202	2,984	106	1,429	89	690	106	2,314	5,298	
DICKSON	2,898	249	2,892	303	6,342	131	3,103	215	1,227	131	4,676	11,018	
DYER	2,638	295	2,900	428	6,261	156	2,795	239	1,260	156	4,450	10,711	
FAYETTE	1,824	155	1,744	303	4,026	144	1,925	111	752	144	2,932	6,958	
FENTRESS	1,344	141	1,512	361	3,358	188	1,456	121	989	188	2,754	6,112	
FRANKLIN	1,965	183	2,073	271	4,492	111	2,106	149	961	111	3,327	7,819	

COUNTY	Female				Female Total	Male				Male Total	Grand Total
	0 - 18	19 - 20	21 - 64	65 ->		0 - 18	19 - 20	21 - 64	65 ->		
GIBSON	3,247	322	3,463	602	7,634	3,497	259	1,579	269	5,604	13,238
GILES	1,597	154	1,654	232	3,637	1,616	119	798	109	2,642	6,279
GRAINGER	1,455	147	1,447	305	3,354	1,456	123	855	148	2,582	5,936
GREENE	3,589	351	4,151	728	8,819	3,857	261	2,019	382	6,519	15,338
GRUNDY	1,064	129	1,245	220	2,658	1,208	102	715	119	2,144	4,802
HAMBLEN	4,538	273	3,714	523	9,048	4,600	293	1,601	216	6,710	15,758
HAMILTON	17,633	1,365	17,627	2,368	38,993	18,580	1,080	7,144	993	27,797	66,790
HANCOCK	498	61	623	148	1,330	557	48	356	69	1,030	2,360
HARDEMAN	1,775	167	1,883	335	4,160	1,759	142	894	152	2,947	7,107
HARDIN	1,692	179	1,910	380	4,161	1,784	160	953	201	3,098	7,259
HAWKINS	3,371	314	3,624	599	7,908	3,477	262	1,844	278	5,861	13,769
HAYWOOD	1,479	145	1,638	269	3,531	1,627	105	571	107	2,410	5,941
HENDERSON	1,812	169	1,922	265	4,168	1,916	148	834	102	3,000	7,168
HENRY	2,011	186	2,140	285	4,622	2,189	162	1,042	97	3,490	8,112
HICKMAN	1,509	153	1,610	192	3,464	1,743	141	864	83	2,831	6,295
HOUSTON	473	37	527	113	1,150	508	34	262	67	871	2,021
HUMPHREYS	1,082	95	1,121	156	2,454	1,117	64	531	57	1,769	4,223
JACKSON	666	58	724	137	1,585	720	61	414	94	1,289	2,874
JEFFERSON	3,215	264	3,102	482	7,063	3,326	220	1,546	204	5,296	12,359
JOHNSON	980	99	1,130	280	2,489	1,062	79	710	152	2,003	4,492
KNOX	19,795	1,589	20,097	2,424	43,905	20,769	1,263	8,721	1,107	31,860	75,765
LAKE	464	37	634	144	1,279	540	41	278	69	928	2,207
LAUDERDALE	1,999	191	2,125	311	4,626	2,092	166	912	124	3,294	7,920
LAWRENCE	2,661	240	2,654	411	5,966	2,831	172	1,330	151	4,484	10,450
LEWIS	775	65	751	129	1,720	759	75	346	61	1,241	2,961
LINCOLN	2,027	152	1,880	285	4,344	2,090	137	897	106	3,230	7,574
LOUDON	2,472	208	2,176	266	5,122	2,553	124	1,020	109	3,806	8,928
MACON	1,796	171	1,663	239	3,869	1,874	136	823	118	2,951	6,820
MADISON	6,601	531	6,730	838	14,700	6,695	415	2,411	336	9,857	24,557
MARION	1,780	175	1,983	228	4,166	1,802	128	864	130	2,924	7,090
MARSHALL	1,817	118	1,687	172	3,794	1,910	111	704	67	2,792	6,586
MAURY	4,986	359	4,700	526	10,571	5,271	290	1,839	186	7,586	18,157
MCMINN	3,066	280	3,203	524	7,073	3,283	213	1,461	227	5,184	12,257
MCNAIRY	1,757	182	2,051	356	4,346	1,932	148	1,130	188	3,398	7,744
MEIGS	792	80	836	90	1,798	827	60	430	45	1,362	3,160
MONROE	2,864	269	2,973	481	6,587	3,128	216	1,516	235	5,095	11,682
MONTGOMERY	9,133	632	8,850	670	19,285	9,385	503	3,057	238	13,183	32,468
MOORE	201	18	186	44	449	252	27	88	18	385	834
MORGAN	1,203	117	1,220	193	2,733	1,280	109	628	97	2,114	4,847
OBION	2,030	184	2,151	294	4,559	2,140	117	878	120	3,255	7,914
OVERTON	1,225	147	1,290	269	2,931	1,350	117	709	137	2,313	5,244
PERRY	551	39	499	76	1,165	524	55	290	31	900	2,065
PICKETT	256	24	289	84	653	303	37	156	46	542	1,195
POLK	1,008	118	1,070	151	2,347	1,044	79	565	70	1,758	4,105
PUTNAM	4,428	368	4,312	751	9,679	4,409	298	2,255	318	7,280	16,959
RHEA	2,379	211	2,266	351	5,207	2,455	169	1,119	131	3,874	9,081
ROANE	2,660	223	3,102	510	6,495	2,941	218	1,613	235	5,007	11,502
ROBERTSON	3,877	297	3,133	371	7,678	4,088	223	1,276	175	5,762	13,440
RUTHERFORD	13,716	1,095	11,786	975	27,572	14,285	782	4,214	414	19,695	47,267

COUNTY	Female				Female Total	Male				Male Total	Grand Total
	0 - 18	19 - 20	21 - 64	65 ->		0 - 18	19 - 20	21 - 64	65 ->		
SCOTT	1,891	183	2,091	387	4,552	2,008	143	1,128	193	3,472	8,024
SEQUATCHIE	1,017	83	1,039	147	2,286	1,041	70	559	49	1,719	4,005
SEVIER	5,549	448	4,869	454	11,320	5,979	349	2,020	162	8,510	19,830
SHELBY	75,481	5,927	68,825	6,815	157,048	77,064	5,255	22,637	2,893	107,849	264,897
SMITH	1,086	109	1,115	163	2,473	1,104	76	516	61	1,757	4,230
STEWART	738	72	797	111	1,718	790	65	395	53	1,303	3,021
SULLIVAN	7,935	707	8,973	1,299	18,914	8,442	584	4,452	565	14,043	32,957
SUMNER	7,912	647	7,400	790	16,749	8,306	518	2,906	312	12,042	28,791
TIPTON	3,675	350	3,505	368	7,898	3,844	294	1,362	128	5,628	13,526
TROUSDALE	518	70	491	73	1,152	500	40	244	34	818	1,970
UNICOI	941	98	1,041	256	2,336	1,051	80	496	119	1,746	4,082
UNION	1,375	128	1,252	156	2,911	1,317	102	692	87	2,198	5,109
VAN BUREN	327	31	333	61	752	357	28	187	49	621	1,373
WARREN	2,872	225	2,818	430	6,345	3,002	194	1,335	191	4,722	11,067
WASHINGTON	5,756	491	6,531	954	13,732	5,961	379	3,039	430	9,809	23,541
WAYNE	832	73	868	166	1,939	865	83	433	72	1,453	3,392
WEAKLEY	1,815	176	2,041	310	4,342	1,899	154	962	111	3,126	7,468
WHITE	1,759	163	1,801	300	4,023	1,869	122	993	122	3,106	7,129
WILLIAMSON	3,294	249	2,694	366	6,603	3,467	241	1,083	152	4,943	11,546
WILSON	5,037	383	4,732	469	10,621	5,234	300	1,859	192	7,585	18,206
Other	3,161	267	3,320	133	6,881	3,360	207	1,288	78	4,933	11,814
<b>Grand Total</b>	<b>385812</b>	<b>31795</b>	<b>374471</b>	<b>47256</b>	<b>839334</b>	<b>402064</b>	<b>25996</b>	<b>159327</b>	<b>20936</b>	<b>608323</b>	<b>1,447,657</b>

Reports include some membership additions that are the result of retroactivity; however, additional retroactivity may still occur. The "Other" county category reflects recipients who are Tennessee residents for which their domicile is temporarily located outside of the state.

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**Dickson County, Tennessee**

People QuickFacts	Dickson County	Tennessee
Population, 2014 estimate	50,575	6,549,352
Population, 2010 (April 1) estimates base	49,654	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	1.9%	3.2%
Population, 2010	49,666	6,346,105
Persons under 5 years, percent, 2014	5.9%	6.1%
Persons under 18 years, percent, 2014	23.4%	22.8%
Persons 65 years and over, percent, 2014	15.1%	15.1%
Female persons, percent, 2014	50.8%	51.3%
White alone, percent, 2014 (a)	92.8%	78.9%
Black or African American alone, percent, 2014 (a)	4.4%	17.1%
American Indian and Alaska Native alone, percent, 2014 (a)	0.5%	0.4%
Asian alone, percent, 2014 (a)	0.6%	1.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2014 (a)	0.1%	0.1%
Two or More Races, percent, 2014	1.8%	1.7%
Hispanic or Latino, percent, 2014 (b)	3.1%	5.0%
White alone, not Hispanic or Latino, percent, 2014	90.1%	74.6%
Living in same house 1 year & over, percent, 2009-2013	85.9%	84.6%
Foreign born persons, percent, 2009-2013	2.1%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	3.3%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	84.2%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	14.2%	23.8%
Veterans, 2009-2013	3,865	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	30.5	24.3
Housing units, 2014	21,076	2,869,323
Homeownership rate, 2009-2013	73.6%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	10.6%	18.3%
Median value of owner-occupied housing units, 2009-2013	\$138,500	\$139,200
Households, 2009-2013	18,647	2,475,195
Persons per household, 2009-2013	2.65	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$21,547	\$24,409
Median household income, 2009-2013	\$44,318	\$44,298
Persons below poverty level, percent, 2009-2013	15.4%	17.6%
Business QuickFacts	Dickson County	Tennessee
Private nonfarm establishments, 2013	897	130,819 <sup>1</sup>
Private nonfarm employment, 2013	12,790	2,394,068 <sup>1</sup>
Private nonfarm employment, percent change, 2012-2013	5.6%	2.1% <sup>1</sup>
Nonemployer establishments, 2013	3,590	470,330
Total number of firms, 2007	5,198	545,348
Black-owned firms, percent, 2007	2.4%	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	0.6%	1.6%
Women-owned firms, percent, 2007	20.6%	25.9%
Manufacturers shipments, 2007 (\$1000)	876,604	140,447,760
Merchant wholesaler sales, 2007 (\$1000)	327,900	80,116,528
Retail sales, 2007 (\$1000)	605,859	77,547,291
Retail sales per capita, 2007	\$12,779	\$12,563
Accommodation and food services sales, 2007 (\$1000)	60,508	10,626,759
Building permits, 2014	202	27,632
Geography QuickFacts	Dickson County	Tennessee
Land area in square miles, 2010	489.90	41,234.90

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**Hickman County, Tennessee**

<b>People QuickFacts</b>	<b>Hickman County</b>	<b>Tennessee</b>
Population, 2014 estimate	24,384	6,549,352
Population, 2010 (April 1) estimates base	24,699	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	-1.3%	3.2%
Population, 2010	24,690	6,346,105
Persons under 5 years, percent, 2014	5.5%	6.1%
Persons under 18 years, percent, 2014	21.8%	22.8%
Persons 65 years and over, percent, 2014	15.6%	15.1%
Female persons, percent, 2014	47.5%	51.3%
White alone, percent, 2014 (a)	92.6%	78.9%
Black or African American alone, percent, 2014 (a)	5.1%	17.1%
American Indian and Alaska Native alone, percent, 2014 (a)	0.5%	0.4%
Asian alone, percent, 2014 (a)	0.3%	1.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2014 (a)	Z	0.1%
Two or More Races, percent, 2014	1.5%	1.7%
Hispanic or Latino, percent, 2014 (b)	2.1%	5.0%
White alone, not Hispanic or Latino, percent, 2014	90.8%	74.6%
Living in same house 1 year & over, percent, 2009-2013	86.5%	84.6%
Foreign born persons, percent, 2009-2013	1.0%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	2.1%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	75.5%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	12.0%	23.8%
Veterans, 2009-2013	1,897	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	38.7	24.3
Housing units, 2014	10,271	2,869,323
Homeownership rate, 2009-2013	77.9%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	5.3%	18.3%
Median value of owner-occupied housing units, 2009-2013	\$100,400	\$139,200
Households, 2009-2013	8,846	2,475,195
Persons per household, 2009-2013	2.59	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$18,383	\$24,409
Median household income, 2009-2013	\$39,581	\$44,298
Persons below poverty level, percent, 2009-2013	17.4%	17.6%
<b>Business QuickFacts</b>	<b>Hickman County</b>	<b>Tennessee</b>
Private nonfarm establishments, 2013	243	130,819 <sup>1</sup>
Private nonfarm employment, 2013	2,134	2,394,068 <sup>1</sup>
Private nonfarm employment, percent change, 2012-2013	-0.5%	2.1% <sup>1</sup>
Nonemployer establishments, 2013	1,669	470,330
Total number of firms, 2007	1,889	545,348
Black-owned firms, percent, 2007	F	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	S	1.6%
Women-owned firms, percent, 2007	25.5%	25.9%
Manufacturers shipments, 2007 (\$1000)	D	140,447,760
Merchant wholesaler sales, 2007 (\$1000)	D	80,116,528
Retail sales, 2007 (\$1000)	76,884	77,547,291
Retail sales per capita, 2007	\$3,233	\$12,563
Accommodation and food services sales, 2007 (\$1000)	7,097	10,626,759
Building permits, 2014	3	27,632
<b>Geography QuickFacts</b>	<b>Hickman County</b>	<b>Tennessee</b>
Land area in square miles, 2010	612.50	41,234.90

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**Houston County, Tennessee**

<b>People QuickFacts</b>	<b>Houston County</b>	<b>Tennessee</b>
Population, 2014 estimate	8,267	6,549,352
Population, 2010 (April 1) estimates base	8,426	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	-1.9%	3.2%
Population, 2010	8,426	6,346,105
Persons under 5 years, percent, 2014	5.0%	6.1%
Persons under 18 years, percent, 2014	21.8%	22.8%
Persons 65 years and over, percent, 2014	19.5%	15.1%
Female persons, percent, 2014	51.2%	51.3%
White alone, percent, 2014 (a)	94.0%	78.9%
Black or African American alone, percent, 2014 (a)	3.2%	17.1%
American Indian and Alaska Native alone, percent, 2014 (a)	0.4%	0.4%
Asian alone, percent, 2014 (a)	0.4%	1.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2014 (a)	0.1%	0.1%
Two or More Races, percent, 2014	1.9%	1.7%
Hispanic or Latino, percent, 2014 (b)	2.3%	5.0%
White alone, not Hispanic or Latino, percent, 2014	91.9%	74.6%
Living in same house 1 year & over, percent, 2009-2013	82.7%	84.6%
Foreign born persons, percent, 2009-2013	1.1%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	1.0%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	80.4%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	9.7%	23.8%
Veterans, 2009-2013	764	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	31.2	24.3
Housing units, 2014	4,170	2,869,323
Homeownership rate, 2009-2013	70.1%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	4.5%	18.3%
Median value of owner-occupied housing units, 2009-2013	\$87,300	\$139,200
Households, 2009-2013	3,423	2,475,195
Persons per household, 2009-2013	2.39	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$18,539	\$24,409
Median household income, 2009-2013	\$35,271	\$44,298
Persons below poverty level, percent, 2009-2013	23.5%	17.6%
<b>Business QuickFacts</b>	<b>Houston County</b>	<b>Tennessee</b>
Private nonfarm establishments, 2013	109	130,819 <sup>2</sup>
Private nonfarm employment, 2013	1,067	2,394,068 <sup>2</sup>
Private nonfarm employment, percent change, 2012-2013	-1.6%	2.1% <sup>2</sup>
Nonemployer establishments, 2013	510	470,330
Total number of firms, 2007	810	545,348
Black-owned firms, percent, 2007	F	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	F	1.6%
Women-owned firms, percent, 2007	17.8%	25.9%
Manufacturers shipments, 2007 (\$1000)	0 <sup>1</sup>	140,447,760
Merchant wholesaler sales, 2007 (\$1000)	0 <sup>1</sup>	80,116,528
Retail sales, 2007 (\$1000)	33,434	77,547,291
Retail sales per capita, 2007	\$4,152	\$12,563
Accommodation and food services sales, 2007 (\$1000)	2,725	10,626,759
Building permits, 2014	1	27,632
<b>Geography QuickFacts</b>	<b>Houston County</b>	<b>Tennessee</b>
Land area in square miles, 2010	200.29	41,234.90

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**Humphreys County, Tennessee**

<b>People QuickFacts</b>	<b>Humphreys County</b>	<b>Tennessee</b>
Population, 2014 estimate	18,135	6,549,352
Population, 2010 (April 1) estimates base	18,538	6,346,275
Population, percent change - April 1, 2010 to July 1, 2014	-2.2%	3.2%
Population, 2010	18,538	6,346,105
Persons under 5 years, percent, 2014	5.9%	6.1%
Persons under 18 years, percent, 2014	22.0%	22.8%
Persons 65 years and over, percent, 2014	19.0%	15.1%
Female persons, percent, 2014	50.4%	51.3%
White alone, percent, 2014 (a)	94.8%	78.9%
Black or African American alone, percent, 2014 (a)	2.7%	17.1%
American Indian and Alaska Native alone, percent, 2014 (a)	0.6%	0.4%
Asian alone, percent, 2014 (a)	0.3%	1.7%
Native Hawaiian and Other Pacific Islander alone, percent, 2014 (a)	Z	0.1%
Two or More Races, percent, 2014	1.5%	1.7%
Hispanic or Latino, percent, 2014 (b)	2.0%	5.0%
White alone, not Hispanic or Latino, percent, 2014	93.2%	74.6%
Living in same house 1 year & over, percent, 2009-2013	89.0%	84.6%
Foreign born persons, percent, 2009-2013	0.5%	4.6%
Language other than English spoken at home, pct age 5+, 2009-2013	2.0%	6.6%
High school graduate or higher, percent of persons age 25+, 2009-2013	84.2%	84.4%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	12.4%	23.8%
Veterans, 2009-2013	1,525	484,901
Mean travel time to work (minutes), workers age 16+, 2009-2013	25.5	24.3
Housing units, 2014	8,875	2,869,323
Homeownership rate, 2009-2013	77.8%	67.8%
Housing units in multi-unit structures, percent, 2009-2013	5.0%	18.3%
Median value of owner-occupied housing units, 2009-2013	\$108,000	\$139,200
Households, 2009-2013	7,396	2,475,195
Persons per household, 2009-2013	2.46	2.52
Per capita money income in past 12 months (2013 dollars), 2009-2013	\$22,183	\$24,409
Median household income, 2009-2013	\$42,846	\$44,298
Persons below poverty level, percent, 2009-2013	13.9%	17.6%
<b>Business QuickFacts</b>	<b>Humphreys County</b>	<b>Tennessee</b>
Private nonfarm establishments, 2013	337	130,819 <sup>1</sup>
Private nonfarm employment, 2013	4,170	2,394,068 <sup>1</sup>
Private nonfarm employment, percent change, 2012-2013	8.1%	2.1% <sup>1</sup>
Nonemployer establishments, 2013	1,126	470,330
Total number of firms, 2007	1,642	545,348
Black-owned firms, percent, 2007	F	8.4%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	S	2.0%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	F	1.6%
Women-owned firms, percent, 2007	S	25.9%
Manufacturers shipments, 2007 (\$1000)	1,052,931	140,447,760
Merchant wholesaler sales, 2007 (\$1000)	57,235	80,116,528
Retail sales, 2007 (\$1000)	181,921	77,547,291
Retail sales per capita, 2007	\$9,964	\$12,563
Accommodation and food services sales, 2007 (\$1000)	17,794	10,626,759
Building permits, 2014	10	27,632
<b>Geography QuickFacts</b>	<b>Humphreys County</b>	<b>Tennessee</b>
Land area in square miles, 2010	530.98	41,234.90

## **SUPPORT LETTERS**



## THREE RIVERS HOSPITAL

451 Highway 13 South • Waverly, Tennessee 37185-2909

931-296-4203 • Fax 931-296-1013

October 2, 2015

Tennessee Health Services and Development Agency  
502 Deaderick Street, Andrew Jackson Bldg, 9<sup>th</sup> Floor  
Nashville, Tennessee 37243

To Whom It May Concern,

I understand TriStar Horizon Medical Center has plans to develop a neonatal intensive care unit and I want to express my support for these efforts.

As a hospital CEO in a rural community, I understand the importance of taking care of patients close to home. TriStar Horizon offers the only OB program West of Nashville between Nashville and Jackson. For adjacent counties and communities like mine in Humphreys County, it is critical that a nearby hospital provide services that we do not offer, like obstetrics.

Women in active labor traveling from Humphreys County all the way to Nashville, over an hour, poses additional risks. Supporting the obstetrics program and NICU at Horizon is critical for the patients in our community.

Thank you for your support

Sincerely,

Freda B. Russell, RN  
CEO/CNO

*"This institution is an equal opportunity provider, and employer"*



October 14, 2015

Tennessee Health Services and Development Agency  
502 Deadrick Street  
Andrew Jackson Bldg., 9<sup>th</sup> Floor  
Nashville, TN 37243

To Whom It May Concern:

I am writing to express my support for TriStar Horizon Medical Center's plans to develop a neonatal intensive care unit.

As Mayor of the fastest growing community in Dickson County, I understand the importance of a great hospital. TriStar Horizon has served our community for many years but with the growing population comes a need for more advanced healthcare services.

Many of the services offered at TriStar Horizon, including labor and delivery, represent the only access point for a large geographic area. In fact, TriStar Horizon's labor & delivery unit represents the only birthing center between Nashville and Jackson, a 140 mile stretch.

Developing a neonatal intensive care unit will provide needed healthcare services for a large geographic region and keep mothers and babies together, rather than babies being transferred to Nashville.

Thank you and we ask for your support of TriStar Horizon's efforts.

Sincerely,

Mayor Linda Hayes  
Town of White Bluff



October 14, 2015

Tennessee Health Services and Development Agency  
502 Deadrick Street, Andrew Jackson Bldg., 9<sup>th</sup> Floor  
Nashville, TN 37243

Dear Sir or Madam:

My name is Jeff Martin and I serve my hometown community of White Bluff, TN as Projects Administrator. I also have the honor to serve on the Board of Trustees of my local hospital, TriStar Horizon Medical Center. Through our Board's activities, I have become aware of Horizon's desires to develop a neonatal intensive care unit, and I would like to express my support for these efforts.

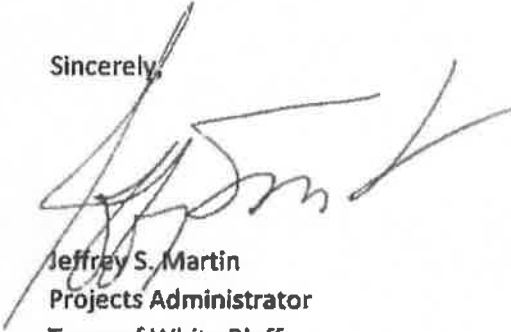
Great communities need great hospitals and TriStar Horizon has been a great hospital for our community for many years. As we grow, hospital services should keep pace and I am proud of the vision and efforts by Horizon leadership to service our region by providing advanced healthcare services as needed.

Many of the services offered at TriStar Horizon, including labor and delivery, represent the only access point for a large geographic area. In fact, TriStar Horizon's labor & delivery unit represents the only birthing center between Nashville and Jackson, a 140 mile stretch.

Developing a NICU will provide much needed healthcare services for a large geographic region and keep mothers and babies together, rather than babies being transferred to Nashville.

Thank you for your support of TriStar Horizon Medical Center's efforts.

Sincerely,

  
Jeffrey S. Martin  
Projects Administrator  
Town of White Bluff



## State of Tennessee

### Health Services and Development Agency

Andrew Jackson, 9<sup>th</sup> Floor, 502 Deaderick Street, Nashville, TN 37243

[www.tn.gov/hsda](http://www.tn.gov/hsda)

Phone: 615-741-2364

Fax: 615-741-9884

November 2, 2015

John Wellborn  
4219 Hillsboro Road, Suite 210  
Nashville, TN 37215

RE: Certificate of Need Application -- TriStar Horizon Medical Center - CN1510-047

For the initiation of neonatal intensive care nursery services in a 6-bed Level II neonatal nursery through renovation of existing space on the 2nd floor of Horizon Medical Center located at 111 Highway 70 East in Dickson, Tennessee. The project does not involve a change to the hospital's existing 157 licensed bed complement, the acquisition of major medical equipment or the initiation or discontinuance of any other health service. The estimated project cost is \$975,500.

Dear Mr. Wellborn:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is [Trent.Sansing@tn.gov](mailto:Trent.Sansing@tn.gov) or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on November 2, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on January 27, 2016.

Mr. Wellborn  
November 2, 2015  
Page 2

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,



Melanie M. Hill  
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA



**State of Tennessee**  
**Health Services and Development Agency**

Andrew Jackson, 9<sup>th</sup> Floor, 502 Deaderick Street, Nashville, TN 37243  
[www.tn.gov/hsda](http://www.tn.gov/hsda) Phone: 615-741-2364 Fax: 615-741-9884

---

MEMORANDUM

TO: Trent Sansing, CON Director  
Office of Policy, Planning and Assessment  
Division of Health Statistics  
Andrew Johnson Tower, 2nd Floor  
710 James Robertson Parkway  
Nashville, Tennessee 37243

FROM: Melanie M. Hill  
Executive Director

DATE: November 2, 2015

RE: Certificate of Need Application  
TriStar Horizon Medical Center - CN1510-047

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on November 2, 2015 and end on January 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: John Wellborn

## LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Dickson County, Tennessee, on or before October 10, 2015, for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Horizon Medical Center (a hospital), owned and managed by Central Tennessee Hospital Corporation, Inc. (a corporation), intends to file an application for a Certificate of Need to initiate neonatal intensive care nursery services in a 6-bed Level II neonatal nursery, by renovation of existing space on its main campus at 111 Highway 70 East in Dickson, TN 37055, at a capital cost estimated at \$975,500.

TriStar Horizon Medical Center is licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, as a 157-bed general hospital. The project does not change the hospital's licensed bed count, and does not contain major medical equipment or initiate or discontinue any other health service.

The anticipated date of filing the application is on or before October 15, 2015. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215, (615) 665-2022.

 10-8-15

(Signature)

(Date)

jwdsg@comcast.net  
(E-mail Address)

# Supplemental #1 -Original -

Horizon Medical Center

CN1510-047

**October 29, 2015**

**3:45 pm**

October 29, 2015

Jeff Grimm, HSD Examiner  
Tennessee Health Services and Development Agency  
Andrew Jackson Building, 9<sup>th</sup> Floor  
502 Deaderick Street  
Nashville, TN 37243

RE: CON Application #1510-047  
Horizon Medical Center NICU

Dear Mr. Grimm:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

**1. Section A, Applicant Profile, Item 6**

**Please provide a title or deed documenting legal interest in the site – the document appears to be missing from the attachments.**

The deed is attached at the end of this letter.

**2. Section B Project Description, Item I 9 (Executive Summary Description).**

**a. Need - If there was an infant at nearby hospitals in the applicant's proposed NICU service area such as Houston County Community Hospital in Erin, TN with BlueCare Network S insurance in need of Level II-B Neonatal Intensive Care Services, would the applicant be able to admit the infant to the proposed neonatal unit for services (absent Federal Emergency Medical Treatment and Labor Act Requirements)? If not, where would the infant be referred for treatment that would reimburse under BlueCare Network S insurance?**

Yes, Horizon will admit those infants. Horizon accepts BCBST Network S insurance for any transfers into the hospital--which will include NICU--and any ER patients needing admission.

Page Two  
October 29, 2015

**b. Have any of the 51 Level II transfers to Centennial Medical Center (CMC) in 2015 year to date, involved referrals by Horizon to CMC of infants covered under Blue Care Network S insurance? Please discuss.**

None of the transfers from Horizon to CMC in that time period was an infant in the Network S program.

**c. Existing Resources-** in addition to the existing hospital NICU units east of Dickson, please include a brief overview of resources available through the Tennessee Department of Health's designated Middle Tennessee Perinatal Region.

Tennessee Code Annotated 68-1-802 (passed in 1974) directed the Department of Health to develop a plan to establish a program for the diagnosis and treatment of certain life-threatening conditions in the perinatal period. The program was to develop a regionalized system of care, including highly specialized personnel, equipment, and techniques to decrease the State's high infant mortality rate and life-long disabilities in surviving newborns.

The regionalization system in Tennessee serves our state by providing the necessary statewide infrastructure for high-risk perinatal care. It addresses the needs of the State's pregnant women and infants. The regionalization system is a key component in the State's capacity to improve birth outcomes, especially infant mortality.

Five Regional Perinatal Center hospitals were designated across the State, to make the highest levels of specialized care available by providing a statewide mechanism to health care providers for consultation and referral of high risk patients; transport of these patients, if necessary; personnel skilled in high risk perinatal care; post-graduate education for physicians, nurses, and other medical personnel; and site visits to local hospitals. The designated center for the 37-county Middle Tennessee Perinatal Region is at Vanderbilt University Medical Center.

More broadly, since the 1970s, the Perinatal Advisory Committee, established by statute as an expert advisory group to the Department of Health, has been responsible for the development and revision of manuals related to "best practice" guidelines for perinatal care in Tennessee. The Perinatal Advisory Committee is composed of 21 members including Regional Perinatal Center directors, experts in perinatal medicine, hospital administrators, nurses and physicians, and provides advice and direction to the Department of Health.

Page Three  
October 29, 2015

Using the national Guidelines from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, work groups of health care providers from across the State have issued, reviewed, and periodically revised and updated Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities, which are included in this CON application with descriptions of Horizon's compliance with those Guidelines. The Committee has also issues Guidelines manuals for Transportation (Neonates and Mothers) and for Educational Objectives for Nurses and Social Workers who serve in the perinatal care programs of Tennessee. As part of the CON review process, members of the Perinatal Advisory Committee will review this application, and will comment on it to the Department of Health, which in turn will include that information in its staff report to the HSDA in the CON review process.

**3. Section B, Project Description, Item II (c).**

**The table of Distance of one way drive times from the service area to the closest NICU destinations on page 26 of the application is noted. For Hickman County residents, it appears the drive times are about the same within 1 hour to Maury Regional Medical Center's existing 8 bed Level IIB NICU and the applicant's proposed Level IIB NICU. Also, the drive times of residents from the county to fully equipped tertiary hospitals in Davidson County that contain the continuum of neonatal care appear to range from 63-68 minutes. Please clarify why someone from Hickman County would go to the proposed Horizon neonatal level II-B nursery in Dickson County for the same Level II service as Maury county or the tertiary hospitals in Davidson County in case more acute symptoms arise? Would this not avoid an unnecessary possibly high risk transport?**

Please see related Table Five-B on page 27 for the answer. The application's stated primary service area, throughout the application, does not include all of Hickman County. It includes only zip code 37025 in northern Hickman County. The round trip times from that zip code to all other NICU's in the table are by far the quickest. Other parts of Hickman County are excluded from the projects service area for the reasons cited in your question.

The application narrative above Table Five-A should have been stated more clearly; Five-A shows the drive times between entire affected counties (measured from their largest communities) and Level II facilities. It would have been better to show the one-way drive data from zip code 37025 in Five-A, as was done for round-trip times in Table Five-B. A revised page 26R is provided after this page, to correct that.

**October 29, 2015****3:45 pm**

**B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.**

The project will be on the second floor of TriStar Horizon Medical Center, located in Dickson, Tennessee on Highway 70 East, one block east of its intersection with Highway 46. The hospital has been at that location for decades and is well known to residents of the project service area, who are generally within 45 minutes' drive of the hospital. Service area residents coming from outside Dickson County can reach TriStar Horizon Medical Center by way of I-40 (5.5 miles from the hospital via Highway 46), Highway 49/46 (from Erin), Highway 46 (from north Hickman County), and Highway 70 (from Waverly). Dickson County residents can reach the hospital in Dickson by more than four State and county highways.

Table Five-A below shows the drive times and distances between the project and the major communities in the primary service area, and comparable drive times and distances to the closest existing NICU's north, east, and south of the project. To highlight the real accessibility issue for families making daily trips to a NICU to be with their infants, Table Five-B on the following page shows *round-trip* drive times for those points. TriStar Horizon's NICU will provide significant improvement in round-trip drive times for service area residents--between one to two hours drive time reduction for 15 of the 20 current options; a half hour or more drive time reduction for all the other options.

<b>Table Five-A: One-Way Distances and Drive Times From Service Area Communities To The Project and to the Closest Existing NICU's</b>												
Primary Service Area Community (County)	To Horizon Med. Center (Dickson)		To Centennial Med. Center (Nashville)		To Saint Thomas Midtown (Nashville)		To Vanderbilt Med. Center (Nashville)		To Maury Reg'l Med. Center (Columbia)		To Gateway Med. Center (Clarksville)	
	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min	Mi.	Min
Dickson (Dickson Co.)	0.9	4"	39.7	48"	39.8	48"	37.8	42"	41.3	54"	40.5	62"
Waverly (Humph. Co.)	29.3	40"	68.1	83"	68.2	83"	66.3	78"	69.7	90"	52.5	72"
Zip 37025 (Hickman Co.)	9.8	19"	39.4	43"	42.0	43"	41.9	32"	32.9	39"	50.3	77"
Erin (Houston Co.)	29.6	41"	68.4	83"	74.3	83"	75.0	86"	70.1	91"	34.2	51"

Source: Google Maps.

Page Four  
October 29, 2015

**4. Section C. Need, Item 1 (Specific Review Criteria: NICU-(5))**

**a. The response indicating compliance with existing Perinatal Care System Guidelines is noted. In terms of physician direction and staffing by Dr. Ismail and the neonatal nurse practitioners of Pediatrix, is there an existing contract, letter of intent or draft operating agreement that documents the responsibilities of the parties for the proposed service? Please clarify.**

The hospital has a professional services agreement with Pediatrix. Copies of relevant pages of the agreement are provided following this page. Pediatrix must provide 24/7 Neonatal Nurse Practitioner ("NNP") coverage, including daily on-site presence. To provide 24/7 coverage, the NNP's are required to be in the community, immediately available (within 30 minutes) to respond to the needs of the hospital/infants. An NNP is currently present for every birth, and is present in the Horizon nursery every day for some period of time. Their duties are spelled out in the agreement. As required by law and hospital bylaws, the NNP's are supervised by Pediatrix neonatologists.

Dr. Ismail, a pediatrix neonatologist, serves as the Medical Director for the nursery program. His duties are administrative in nature and are set forth in the professional services agreement. He is also responsible for supervision of the NNP's, which is shared with other Pediatrix neonatologists.

If NICU designation is awarded, the neonatology professional services, both physician and NNP, will continue and be modified, as necessary, to ensure they are in compliance with the Perinatal Guidelines.

**b. How will Dr. Ismail's time be split between Horizon and Centennial Medical Center?**

Dr. Ismail will be one of eleven to twelve Board-certified neonatologists who will rotate daily through the Horizon NICU. The Pediatrix organization schedules their assignments to each of the several NICU's that Pediatrix covers.

**c. It appears the hospital currently utilizes neonatal nurse practitioners of Pediatrix. Please provide license verification for NNPs the applicant plans to utilize for the proposed unit at this time.**

Their names and licensure verification are provided at the end of this response letter. While those living near Dickson will be used routinely, others may fill in for them as needed.

**October 29, 2015****3:45 pm**Supplement Agreement  
LEVEL I NURSE

**PROFESSIONAL SERVICES AGREEMENT ADDENDUM  
MEDICAL DIRECTOR - OPEN STAFF (HCA-527PED Rev 8/2010/PEDIATRIX)  
CONTRACT HRZMC-79905, SUPPLEMENT 0**

This Addendum is attached to, made a part of and executed simultaneously with that certain Professional Services Agreement between the undersigned.

**1. Operation of the Service**

- A. Contractor shall supervise the professional operations of the Service. Those supervisory duties shall be discharged through the Medical Director designated below.
- B. ~~Contractor's Representatives shall be permitted to participate in the activities of the Service in the same manner, and subject to the same conditions, as other practitioners holding membership or privileges in the Service. In addition it is agreed:~~
- i. Contractor's Representatives shall prepare timely, complete and accurate medical records in accordance with the policies and procedures of Facility and all professional standards applicable to medical records documentation. All of such records shall be and remain the property of Facility. Contractor and each Contractor's Representative shall have access to those records created by the respective Contractor's Representative as may be necessary for the continuing care of the patient and as otherwise permitted by law.
  - ii. Contractor's Representatives shall participate actively in the affairs of the Medical Staff, including, without limitation, serving on committees and discharging such other obligations as may be requested by the Medical Staff, Governing Body or any duly appointed officer or committee thereof.
- C. Contractor agrees that, as requested by Facility, Contractor shall negotiate in good faith for participation by Contractor and any Contractor's Representative designated by Facility in such programs and/or networks in which Facility may participate with health maintenance organizations, preferred provider organizations, other payors, and physician-hospital organizations. Facility agrees to assist Contractor in negotiating terms of participation.
- D. Contractor shall conform to any and all lawful directives issued from time to time by Facility's Chief Executive Officer provided that such directives are consistent with the scope and principles of this Agreement.
- E. All patient records prepared and developed by Contractor and maintained by Facility or documents created by Contractor at Facility's request as part of the Services for the purpose of documenting clinical diagnosis, treatment, and outcome will be the property of Facility.

**2. Director of Service**

**M. Sami Ismail, MD** shall serve as Director of the Service and perform the following undertakings:

- A. Participate as requested in the administrative functions as necessary to ensure the effective and efficient management of the Service.
- B. Participate as requested in Facility's plans and programs adopted to assess and improve the quality and efficiency of Facility's services, including, but not limited to, quality assessment and improvement, utilization review, risk management, and infection control.
- C. Provide such supervision, management and oversight to the Service to assure that the professional services rendered meet or exceed accepted standards of care.
- D. Participate as requested in the long range planning of Facility, including, but not limited to, equipment selection, budgeting, and staffing.
- E. Support the Facility's medical education and employee inservice programs at the Facility, and develop such educational programs for said programs as the Facility shall reasonably request.
- F. Cooperate with Facility regarding administrative, operational or personnel problems in the Service and promptly inform Facility and appropriate Medical Staff committees of professional problems in the Service in accordance with Medical Staff bylaws, rules and regulations and Facility policy.

**October 29, 2015****3:45 pm**

- G. Assist Facility in obtaining and maintaining accreditation and all licenses, permits and other authorizations, plus achieving all accreditation standards which are dependent upon, or applicable to, in whole or in part, the manner in which the Service is conducted.
- H. Assure the maintenance of accurate, complete and timely patient and other records regarding the Service in order to facilitate the delivery of quality patient care and provide the information required for Facility to obtain payment for its Services.
- I. With the assistance of Facility staff, provide the Facility's Chief Executive Officer or his designee with all requested written reports, including reports that may be addressed in performance review standards or other documents.
- J. Supervise Neonatal Nurse Practitioners in accordance with State and other applicable standards.

### **3. Facilities and Services Provided by Facility**

- A. Facility shall provide on the Facility premises the space designated by the Facility for the Service, plus any expendable supplies, equipment, and services necessary for the proper operation of the Service. The minimum services to be provided by the Facility are janitor, standard facility telephone, laundry, and utilities.
- B. Facility shall employ sufficient non-physician personnel as it deems necessary for the proper operation of the Service. All such non-physician personnel shall be recruited and paid by Facility. Facility will have administrative and executive control over the non-physician personnel provided by the Facility, including the sole right to determine the hours of work, discipline and termination of such personnel. The Director of the Service shall direct and supervise the technical work and services of such personnel. The parties agree that the staffing level of non-physician personnel currently available is presently sufficient for the extent of present operations. Contractor will notify Facility of any failure on the part of such non-physician personnel to perform properly their assigned duties. Contractor recognizes the special nature of the relationship that exists between Facility and its personnel in that the recruiting and training of such personnel by Facility is costly and time consuming and, therefore, Contractor agrees that Contractor will not, during the term of this Agreement directly or indirectly through any means or manner, impair or initiate any attempt to impair the relationship which exists between Facility and the personnel employed or retained by Facility, or employ or contract with such personnel.
- C. The obligations of Facility under this Section shall be subject to Facility regulatory and budget restraints.

### **4. Description of Duties**

- A. **In House and On-Call Schedule Requirements:** Contractor will provide neonatal nurse practitioner coverage 24 hours per day, 7 days per week as set forth herein. Contractor will provide in-house neonatal nurse practitioner coverage an average of four (4) hours per day, seven days per week. Contractor will provide on-call neonatal nurse practitioner coverage for all other hours not set forth above.
- B. **Position Description:** The purpose of the neonatal Nurse Practitioner job description is to define the duties and set requirements for filling the position according to the parameters set by Contractor.
- C. **Requirements:** Each Neonatal Nurse Practitioner shall provide, upon request, proof of certification or successful completion of qualified programs as neonatal nurse practitioner. Advanced practice RN license, NCC Certification.
- D. **Positional Goal:** To provide excellence in care of the ill neonate and their family to promote professionalism in the role of practitioner care provided through education, team participation, quality performance support and participation, and pursuit of furthering individual knowledge base.
- E. **Functions of the Neonatal Nurse Practitioner:**
  - i. Obtain and document a complete patient health history, to include all obstetrical, family, and psychosocial aspects.
  - ii. Perform a complete newborn physical exam, determine gestational age and document all clinical findings.
  - iii. Develop a patient problem list, identify and prioritize problems based on physical findings and other information.
  - iv. In collaboration with the attending neonatologist, develop and implement a plan of care from the problem list and evaluate patient status.
  - v. record assessment data, plans of care and evaluation of the care in the medical record,
  - vi. Participate in patient care rounds.

**October 29, 2015****3:45 pm**

- vii. Assess the perinatal family and make appropriate referrals, in collaboration with the attending neonatologist, based on the identification of risk factors.
- viii. Attend high-risk deliveries and emergency situations when requested by a physician.
- ix. Provide information and education to the parents concerning infant's status by such means as parent conferences, bedside teaching, and telephone communication.

**F. Clinical Practice Protocols and Schedules:**

- i. Clinical Practice Protocol, as outlined in the following section must be consistent with written unit policies approved yearly by the medical director. Approved policies will comply with the allied health privileges of the advanced practitioner as well as the state licensing authority.
- ii. Initiate and/or administer the following measures in accordance with the plan of care developed with the supervising physician.
  - a. Fluid and Nutrition in accordance with the patient's health problems.
  - b. Environment control (radiant warmer, isolette, and bassinet) in accordance with patient's health care problems.
  - c. Assist with the management of respiratory, cardiac, gastrointestinal, neurological, renal, hematological, and immunological and other pathological entities of the neonate.
  - d. Assist with the management of Sepsis or suspected Sepsis.
  - e. Assist with the management of surgical patients.
- iii. Initiate and/or administer the following in accordance with the plan of care developed with the supervising physician:
  - a. Antibiotic Therapy
  - b. Emergency Drugs
  - c. IV Fluids and Electrolyte Therapy
  - d. Other drugs as medically necessary
  - e. Initiate and render the following measures as per credentials upon the direction of the supervising physician and in accordance with policies and procedures approved by the medical director.
  - f. Insertion of umbilical arterial Catheters/ umbilical venous catheters
  - g. Thoracentesis or insertion of chest tubes in life-threatening situations
  - h. Percutaneous Venous Catheter Insertions
  - i. Lumbar punctures
  - j. Suprapubic taps
  - k. Endotracheal Intubations
  - l. Arterial punctures
  - m. Venipunctures
  - n. Ventricular Reservoir Taps
  - o. Exchange Transfusions
  - p. Stabilization of infants in the delivery room
  - q. PIV Placement
  - r. Circumcision

**October 29, 2015****3:45 pm**

- s. Frenulum Incision
- t. Hearing Screen
- u. Other diagnostic data, including lab tests, x-rays, and other tests as indicated
- v. Attend high risk neonatal transports as requested by supervising
- w. Participate in discharge planning

**5. No Employment**

- A. Facility covenants that during the term of this Agreement, any renewals thereof and for a period of two (2) years thereafter neither it, nor any subsidiary of Facility, will employ or otherwise engage any Contractor's Representative that has been employed or otherwise engaged by Contractor or introduced by Contractor to Facility, or in any manner seek to induce such persons to leave his or her employment or terminate his or her employment relationship with Contractor (including without limitation for or on behalf of a subsequent employer of the Contractor's Representative).

**PER FACILITY POLICY LL.001, GENERAL STATEMENTS ON AGREEMENTS WITH REFERRAL SOURCES, APPROVAL PROCESS, ET.SEQ., PAYMENTS PURSUANT TO THIS AGREEMENT, IF ANY, WILL BE MADE ONLY FOR SERVICES PERFORMED AFTER THE AGREEMENT HAS BEEN SIGNED BY BOTH THE CONTRACTOR AND THE FACILITY UNLESS OTHERWISE APPROVED BY FACILITY'S LEGAL OPERATIONS COUNSEL. SERVICES PERFORMED PRIOR TO THIS DATE WILL NOT BE COMPENSATED, UNLESS OTHERWISE APPROVED BY FACILITY'S LEGAL OPERATIONS COUNSEL.**

IN WITNESS WHEREOF, Facility and Contractor have duly executed this Addendum as of the dates set out beneath their respective signatures.

**CONTRACTOR:**

Pediatrics Medical Group of Tennessee, P.C.

By: \_\_\_\_\_

Title: Alan Oliver, MBA, MHA - Authorized Signatory

Dated: 7.10.14

**FACILITY:**

Central Tennessee Hospital Corporation d/b/a TriStar Horizon Medical Center

By: /S/John Marshall  
Facility Chief Executive Officer

Dated: July 9, 2014

**October 29, 2015****3:45 pm**

Page Five  
October 29, 2015

**d. In addition to Dr. Ismail's qualifications and resume in the attachments, there are also resumes for Dr. Michael Hawkins and Dr. Erin Steidl. Please briefly discuss the responsibilities/roles these physicians will have with the applicant's proposed NICU unit.**

Dr. Michael Hawkins, board certified OB/GYN, is the Division Chief of Maternal/Child Care at TriStar Horizon Medical Center. Dr. Erin Steidl, Doctor of Osteopathy, works with Dr. Hawkins at the Women's Health Center, PLLC. Both physicians are supportive of the proposed NICU unit to allow continuation of their dedication to family centered care and supporting non-separation of mother and baby.

**e. Who provides the actual neonatal transport service at present and in what way might this service change if the proposed Level IIB NICU beds receive CON approval? In your response, please also address the availability of air transport.**

Horizon has a transfer agreement with Centennial Medical Center. Centennial operates its own regional transport system, with its own EMS vehicle. The team leaves Centennial within an hour of request, picks up the newborn at Horizon, and manages its care during transport to the Centennial NICU. Implementation of the NICU will not require any change in this arrangement. Air ambulance service, if required, is provided by Vanderbilt LifeFlight helicopters.

**f. Please provide the types of pediatric sub-specialties that will be available to support the proposed NICU.**

Pediatric subspecialties other than neonatologists are required for Level III NICU's. Such subspecialists available to the TriStar Horizon NICU routinely will be medical staff of Centennial Women's and Children's Hospital. Currently, they include the following pediatric specialties and subspecialties: anesthesia, cardiology, critical care, endocrinology, gastroenterology, hematology-oncology, neonatology, neurology, surgery, plastic surgery, urology, and ophthalmology,

Page Six  
October 29, 2015

**g. Is there a pool of other board certified neonatologists that will be available to care for Level IIB infants? If possible, please provide a copy of their Tennessee license and licensure profile.**

At the current time, Pediatrix Medical Group has a contract with Dr. Nester Ojeda, pediatrician, who routinely sees all well newborns admitted at TriStar Horizon Medical Center. Pediatrix Medical Group employs several neonatologists who will be available to rotate daily through the NICU to make rounds on its infants. Their names and licensure data are attached at the end of this letter.

**h. Please clarify if radiology services will be available 24 hours a day including the capability to perform portable radiological studies in the nursery.**

Yes, radiology services are available 24 hours a day including the capability to perform portable radiological studies in the nursery.

**i. With respect to the responses to the Perinatal Guidelines provided for this standard, Item A.4 on page 41 appears to indicate that high risk deliveries are currently taking place at the hospital with 2 RNs and an NNP attending all high risk deliveries. Why are high risk deliveries occurring at the hospital? Is the hospital admitting high risk females in lieu of coordinating referrals to hospitals with existing Level IIB – III NICU units in Davidson County? Please clarify.**

No, TriStar Horizon Medical Center is not admitting high risk females in lieu of coordinating referrals to hospitals with existing Level II-III NICU's in Davidson County.

IN CY2015 year to date, TriStar Horizon Medical Center has transferred 22 women to higher level of care facilities in Davidson County for diagnoses ranging from preterm labor, premature rupture of membranes, preeclampsia, to cholelithiasis (gallstones) requiring surgical intervention.

**October 29, 2015****3:45 pm**

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October 29, 2015

Unfortunately, there are times when a high risk patient presents to TriStar Horizon Medical Center and transport is not a viable option--for example, when a woman presents in preterm labor with advanced dilatation, which would pose a high risk for transport due to the possibility of the infant delivering while en route to a higher level of care facility. In such cases, TriStar Horizon Medical Center follows the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Level, Staffing and Facilities by delivering the preterm patient who is not stable for transport and by stabilizing newborn infant until transfer to a higher level of care facility.

There are also instances when the patient's obstetrician requests the presence of the neonatal nurse practitioner (NNP) to attend a delivery. These may include patients who present with preterm labor, meconium amniotic fluid, or possible fetal compromise.

**5. Section C, Need, Item 5**

**The utilization of existing hospitals with Level IIB – III NICU beds is noted. Based on the applicant's relationship through common ownership to Hendersonville Medical Center, please provide a project status update for the 6-bed Level IIB NICU unit approved in its application, CN1302-002A.**

That NICU project is still under construction, with an estimated opening date at the end of January, 2016.

**6. Section C, Need, Item 6**

**As a complement or addition to Table 9-B on page 59, please provide the number of transfers by Horizon year to date in 2015 to other hospitals with Level IIB – III beds with identification of medical reason e.g. low birth weight, very low birth weight, premature, etc.**

Please see the following page for a complete listing of such transfers YTD2015.

**October 29, 2015****3:45 pm****2015 Neonatal Transfers from TriStar Horizon Medical Center to Higher Level of Care Facility****January**

- Respiratory Distress, Hypoglycemia
- Neonatal Abstinence Syndrome, withdrawal treatment

**February**

- Prematurity, Hypoglycemia, Rule-out Sepsis
- Hypoglycemia
- Prematurity, Intra-Uterine Growth Restricted

**March**

- Prematurity, Respiratory Distress
- Prematurity, Respiratory Distress
- Hypoglycemia

**April**

- Respiratory Distress
- Bilateral Cleft lip & palate
- Neonatal Abstinence Syndrome
- Prematurity, Respiratory distress

**May**

- Prematurity, Respiratory Distress
- Respiratory Distress, Rule-out Sepsis
- Hypoglycemia
- Meconium Aspiration
- Epidermolysis Bullosa

**June**

- Hypoglycemia
- Hypoglycemia
- Hypoglycemia

**July**

- Hypoglycemia
- Prematurity, Respiratory Distress
- Persistent Vomiting for bowel evaluation
- Prematurity, Respiratory distress, Hypoglycemia, Rule-Out Neonatal Abstinence Syndrome
- Prematurity, Respiratory distress, Rule-out sepsis
- Respiratory distress, Meconium aspiration
- Prematurity, Respiratory distress
- Prematurity, Respiratory distress

- resp
- Respiratory distress, Rule-out sepsis

**August**

- Hypoglycemia
- Hypoglycemia, Neonatal Abstinence Syndrome
- Hypoglycemia
- Prematurity, Intra-Uterine Growth Restricted
- Respiratory distress
- Prematurity, Hypoglycemia
- Prematurity, Respiratory distress
- Neonatal Abstinence Syndrome

**September**

- Respiratory distress, Hypoglycemia
- Rule-out malrotation and mid-gut volvulus
- Hypoglycemia
- Prematurity, Respiratory distress, Rule-out sepsis
- Rule-out sepsis
- Hypoglycemia
- Hypoglycemia

**October**

- Abdominal distention
- Hypoglycemia, Rule-out sepsis
- Prematurity, Respiratory distress

Page Eight  
October 29, 2015

**7. Section C, Economic Feasibility, Item 2 (Funding)**

**Please provide a letter from the hospital CFO that confirms the availability of cash reserves to support the project.**

The funding will be provided by HCA, Inc. through TriStar Health System (the hospital's Division office); a TriStar funding letter was included in the Attachments to the application. If it is missing from your document, another copy is attached following this page.

**8. Section C, Item 4 (Projected Data Chart)**

**The charts are noted. For the hospital as a whole Net Operating Income (NOI) is expected to improve from a loss of (\$3,124,197) in FY2014 to \$4,620,000 in FY2017. The projected favorable NOI performance from FY2014 to FY 2017 appears to be related to several factors, including a 13.8% increase in patient days and a 32.6% increase in gross operating revenue. Although total operating expenses of the hospital are also expected to increase (by approximately 18.8%), it is unclear how the hospital expects the financial performance to improve to this degree. Please explain the reasons for the significant improvement in the hospital's NOI as projected in FY2017.**

TriStar Horizon is projecting net operating income of \$552,000 in CY2015 due to a 9% increase in admissions and a 19% increase in ER visits from the opening of the Natchez Emergency Department (its satellite on I-40) in June this year. The hospital projects net operating income of \$2,618,000 in CY2016 for two reasons.

First, a full year of operation of the satellite Natchez ED on I-40.

Second, the recruitment of two general surgeons in September and November of 2015. Horizon projects net operating income of \$4,620,000 in CY2017, in part due to moving to 24/7 availability in its cardiac catheterization laboratory, and also to recruitment of at least one additional cardiologist, two orthopedists, and Ob/Gyn, and a gastroenterologist--in addition to the NICU proposed in this application.

**October 29, 2015****3:45 pm** TriStarHealth.com110 Winners Circle, First Floor  
Brentwood, TN 37027  
(615) 886-4900

October 1, 2015

Melanie M. Hill, Executive Director  
Tennessee Health Facilities Commission  
Andrew Jackson State Office Building, Ninth Floor  
500 Deaderick Street  
Nashville, Tennessee 37243

Dear Mrs. Hill:

TriStar Horizon Medical Center is applying for a Certificate of Need to upgrade its Level I Nursery to a Level II Neonatal Intensive Care Unit. This will require a capital expenditure of approximately \$975,500.

As its Chief Financial Officer, I am writing to confirm that TriStar Health System, the Division office to which this hospital belongs, will fund the project in cash with a cash transfer from HCA, Inc. to TriStar. The application includes HCA Inc's financial statements documenting that sufficient cash reserves and operating income exist to accomplish that.

Sincerely,

A handwritten signature in black ink, appearing to read "CEL", written over a horizontal line.

Christopher E. Lawson,  
TriStar Chief Financial Officer

CEL/vg

Page Nine  
October 29, 2015

**9. Section C, Economic Feasibility, Item 5**

**The tables on page 74 reflecting the average gross charges, net charges and net income of the hospital and the proposed NICU are noted. In comparing to the Projected Data Charts for both the hospital and the proposed unit on pages 70 and 72, respectively, HSDA suggests that clarification be provided by changing the labels of the tables to reflect that Table 10-A applies to the Hospital with NICU and Table 10-B applies to the proposed NICU only.**

Attached following this page is revised page 74R, with Table Ten-A relabeled to indicate that it includes NICU, and Table Ten-B relabeled to clarify that it is for the NICU only.

**10. Section C, Orderly Development, Item 3**

**a. Direct patient care staffing of the proposed NICU by 9.0 full time equivalent (FTE) Registered Nurses, 2.2 FTE Respiratory Therapists and a 0.4 Pharmacist is noted. Are the RN and RT staffing ratios the same for all 3 shifts of the unit? Please clarify.**

Yes, the RN and RT staffing ratio will remain the same each of these services will work 12 hour shifts. The RN ratio will be 1:2, and the RT ratio will be 1:6.

**b. Given the applicant's contractual relationship with Pediatrix, please also identify the FTEs for direct patient care staffing by neonatal nurse practitioners of that organization.**

There will be 24 hour 7 day per week coverage by the NNP's for the Level II NICU, as described in the response to question #4 above. The equivalent FTEs will be 4.2.

**October 29, 2015****3:45 pm**

**C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.**

<b>Table Ten-A: Average Charges, Deductions, Net Charges, Net Operating Income TriStar Horizon Medical Center (Including NICU)</b>		
	<b>CY2017</b>	<b>CY2018</b>
Patient Days	21,840	22,277
Admissions or Discharges	5,294	5,400
Average Gross Charge Per Day (IP+OP)	\$24,162	\$25,582
Average Gross Charge Per Admission (IP+OP)	\$99,679	\$105,536
Average Deduction from Operating Revenue per Day	\$20,049	\$21,270
Average Deduction from Operating Revenue per Admission	\$82,712	\$87,746
Average Net Charge (Net Operating Revenue) Per Day	\$4,113	\$4,312
Average Net Charge (Net Operating Revenue) Per Admission	\$16,967	\$17,790
Average Net Operating Income after Expenses, Per Day	\$391	\$465
Average Net Operating Income after Expenses, Per Admission	\$1,611	\$1,916

*Source: Hospital management.*

<b>Table Ten-B: Average Charges, Deductions, Net Charges, Net Operating Income TriStar Horizon Medical Center--NICU Only</b>		
	<b>CY2017</b>	<b>CY2018</b>
Patient Days	1,105	1,300
Admissions or Discharges	85	100
Average Gross Charge Per Day	\$3,435	\$3,675
Average Gross Charge Per Admission	\$44,659	\$47,780
Average Deduction from Operating Revenue per Day	\$1,824	\$2,025
Average Deduction from Operating Revenue per Admission	\$23,718	\$26,330
Average Net Charge (Net Operating Revenue) Per Day	\$1,611	\$1,650
Average Net Charge (Net Operating Revenue) Per Admission	\$20,941	\$21,450
Average Net Operating Income after Expenses, Per Day	\$317	\$465
Average Net Operating Income after Expenses, Per Admission	\$4,118	\$6,050

*Source: Hospital management.*

**October 29, 2015****3:45 pm**

Page Ten  
October 29, 2015

**c. Please also describe how the following positions will be accounted for in the proposed proposed NICU staffing plan: Board Certified Obstetrician, Board Certified Pediatrician, NICU Medical Director/Assistant Director, and a Nurse Manager.**

Horizon's medical staff already has two Board Certified Obstetricians (a third is being recruited). Board Certified Pediatric coverage is already contracted and in place. The NICU Medical Director, Dr. Sami Ismael, is a Board Certified Neonatologist. The NICU Nurse Manager will be Kristin Thornberry, RN. The NICU is too small to require an Assistant Director.

#### **Additional Items From the Applicant**

Attached at the end of this letter are additional support letters for the project. With them, you should now have the following support letters on file. As others arrive we will submit them to your office.

1. Subhi Ali, MD, FACS, former HSDA Board member and former President of the Tennessee Medical Association;
2. Donny J. Bear, Director of the Dickson County Emergency Medical Services;
3. Hon. David A. Shepard, Representative, District 69, Tennessee General Assembly;
4. Linda J. Frazier, Director of Finance and Business, Dickson County Board of Education;
5. Bradley Barber, CEO, Decatur and Houston County Hospitals;
6. Freeda Russel, CEO, Three Rivers Hospital;
7. Mayor Linda Hayes, Town of White Bluff;
8. Jeffrey Martin, Project Administrator, Town of White Bluff.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,



John Wellborn  
Consultant

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

**October 29, 2015**

**3:45 pm**

**WAVERLY CLINIC, P.C.**

806 EAST MAIN STREET - P.O. BOX 786

WAVERLY, TENNESSEE 37185-0786

PHONE (931) 296-7788 FAX (931) 296-7130

SUBHI D. ALI, M.D., F.A.C.S., F.I.C.S.  
GENERAL SURGERY

ARTHUR W. WALKER, M.D.  
FAMILY PRACTICE

MAYSOON SHOCAIR-ALI, M.D., F.A.C.P.  
INTERNAL MEDICINE & GASTROENTEROLOGY

October 27, 2015

Ms. Melanie Hill  
Tennessee Health Services and Development Agency  
502 Deaderick Street  
Andrew Jackson Bldg, 9th Floor  
Nashville, TN 37243

Dear Ms. Hill,

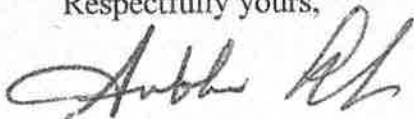
This letter is in support of the application of Horizon Medical Center- NICU CON.

I am fully aware of the problems related to the fact that rural Tennessee between Nashville and Jackson does not have a single NICU. The only obstetrics program remaining in that 140 miles rural stretch of Interstate 40 is at TriStar Horizon Medical Center which is the only regional Hospital in our area. All other obstetrics departments in the area that existed when we started Waverly Clinic in 1976 have since closed as a result of the many negative changes in rural health care.

A significant percentage of the babies born at Horizon are being transferred to larger hospitals in Nashville for a Level II NICU due to the demands of new protocols that can only be met by a NICU. That is not in the best interest of the mothers and their babies or the citizens of the State of Tennessee who reside in the aforementioned area.

I strongly endorse the CON supra without any reservations and feel that approving it is vital to the stability and advancement of obstetric care in a growing area with a large percentage of young reproducing adults. It is in the best interest of the health and welfare of the people who live in the State of Tennessee.

Respectfully yours,



Subhi D. Ali, MD, FACS  
Former President,  
Tennessee Medical Association

**October 29, 2015**

**3:45 pm**

**DICKSON COUNTY AMBULANCE SERVICE**

**284 Cowan Rd.**

**Dickson, TN. 37055**

**Business Office: 615-446-1732**

**Office Fax: 615-446-8359**

**dbear@dicksoncountyttn.gov**

**Donny J. Bear  
DIRECTOR**

October 14, 2015

Tennessee Health Services and Development Agency  
502 Deadrick Street, Andrew Jackson Bldg., 9<sup>th</sup> Floor  
Nashville, TN 37243

To Whom It May Concern:

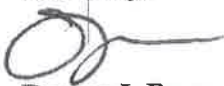
I understand TriStar Horizon Medical Center has plans to develop a neonatal intensive care unit, and I would like to express my support for these efforts.

As the Emergency Medical Service Director, I understand the importance of a great hospital. TriStar Horizon has served the community for many years but with the growing population in Dickson and surrounding counties, developing more advanced healthcare services is necessary.

Many of the services offered at TriStar Horizon, including labor and delivery, represent the only access point for a large geographic area. In fact, TriStar Horizon's labor & delivery unit represents the only birthing center between Nashville and Jackson, a 140 mile stretch.

Developing a NICU will provide needed healthcare services for a large geographic region and keep mothers and babies together, rather than babies being transferred to Nashville.  
Thank you for your support.

Sincerely,



Donny J. Bear  
Director  
Dickson County EMS

**October 29, 2015**

**3:45 pm**

**MEMBER**

INSURANCE AND BANKING COMMITTEE  
SUB – INSURANCE AND BANKING COMMITTEE  
LOCAL GOVERNMENT  
ETHICS COMMITTEE

**MEMBER JOINT SELECT COMMITTEE**

FISCAL REVIEW



## House of Representatives

State of Tennessee

NASHVILLE

October 19, 2015

**DAVID A. SHEPARD**  
HOUSE DISTRICT 69  
rep.david.shepard@capitol.tn.gov  
34 LEGISLATIVE PLAZA  
NASHVILLE, TN 37243-0169  
(615) 741-3513  
1-800-449-8366, EXT 13513  
FAX: (615) 253-0244

Tennessee Health Services and Development Agency  
Melanie M. Hill, Director  
Andrew Jackson Building, 9<sup>th</sup> Floor  
502 Deaderick Street  
Nashville, TN 37243

Dear Director Hill:

TriStar Horizon Medical Center has plans to develop a neonatal intensive care unit (NICU). By this letter, I offer my full support to their effort.

TriStar has served our community and the surrounding counties for many years. As the area has grown in population, TriStar's service and their commitment to offer more advanced healthcare has grown. Being a pharmacist, I understand the need and importance of having a fully functioning, excellent hospital in our area.

Many of the services offered at TriStar Horizon, including the labor and delivery unit, represent the only access point for a large geographic area. TriStar Horizon's labor and delivery unit is the only birthing center between Nashville and Jackson.

The development of a NICU will greatly enhance healthcare in this region. If a problem occurs at birth, keeping the mother and baby together at a crucial time is important. The baby will not have to be transferred to Nashville.

I appreciate your review and consideration of TriStar Horizon's application for the Certificate of Need for the neonatal intense care unit.

Sincerely,

A handwritten signature in black ink that reads "David A. Shepard".

David A. Shepard  
Representative, District 69  
109<sup>th</sup> Tennessee General Assembly



**DICKSON COUNTY BOARD OF EDUCATION**

*Linda J. Frazier, Director of Finance/Business*

817 North Charlotte Street

Dickson, TN 37055

Phone 615-446-7571 – Fax 615-441-1375

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

October 26, 2015

Tennessee Health Services and Development Agency  
502 Deadrick Street, Andrew Jackson Bldg., 9<sup>th</sup> Floor  
Nashville, Tennessee 37243

To Whom It May Concern:

I understand TriStar Horizon Medical Center has plans to develop a neonatal intensive care unit, and I would like to express my support for these efforts.

As a community leader and having served as County Mayor, I understand the importance of a great hospital and know that the availability of a quality healthcare has gone a long way when new industry make the decision to come to Dickson County. TriStar Horizon has served the community for many years but with the growing population in Dickson and surrounding counties, developing more advanced healthcare services is necessary.

Many of the services offered at TriStar Horizon, including labor and delivery, represent the only access point for a large geographic area. In fact, TriStar Horizon's labor and delivery unit represents the only birthing center between Nashville and Jackson, a 140 mile stretch. Developing a NICU will provide needed healthcare services for a large geographic region and keep mothers and babies together, rather than babies being transferred to Nashville. I have personal knowledge of a family who chose to stay in Dickson for the birth of their fourth child only to have that baby need further medical attention which TriStar Horizon could not provide. The family then had to travel back and forth to Nashville, maintain a household consisting of three school age children and work duties of the father. The development of a NICU in Dickson County would help families in so many ways.

Thank you in advance for your consideration and support.

Best regards,

Linda J. Frazier

Director of Finance and Business

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

October 1<sup>st</sup>, 2015

Tennessee Health Services and Development Agency

502 Deadrick Street, Andrew Jackson Bldg, 9<sup>th</sup> Floor

Nashville, TN 37243

To Whom It May Concern,

I understand TriStar Horizon Medical Center has plans to develop a neonatal intensive care unit and I want to express my support for these efforts.

As a hospital CEO in a rural community, I understand the importance of taking care of patients close to home. TriStar Horizon offers the only OB program West of Nashville between Nashville and Jackson. For adjacent counties and communities like mine in Houston and Decatur County, it is critical that a nearby hospital provide services that we do not offer, like obstetrics.

Women in active labor from Houston and Decatur County traveling all the way to Nashville, over an hour, poses additional risks. Supporting the obstetrics program and NICU at Horizon is critical for the patients in our community.

Thank you for your support

Sincerely,



Bradley Scott Barber

Decatur and Houston Co. CEO

# **SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

**October 29, 2015**

**3:45 pm**

Address New Owner:	Map-Parcel Numbers:	Send Tax Bills To:
Central Tennessee Hospital Corporation c/o Columbia/HCA Healthcare Corporation One Park Plaza Nashville, TN 37202-0550	Dickson County: <i>OK</i> Map 111A-A, Parcel 1.00 Map 110D-D, Parcel 1.13 Map 111A-A, Parcel 15.00 Map 111A-A, Parcel 1.02 Map 110D-D, Parcel 2.00 Map 110D-D, Parcel 2.00-001 Map 110D-D, Parcel 2.00-002 Map 110D-D, Parcel 2.00-003  Cheatham County: Map 55C/49N-C, Parcel 10.00 Map 55C/55C-J, Parcel 7.00	same as new owner
This instrument prepared by: Waller Lansden Dortch & Davis (JRC) 511 Union Street, Suite 2100, P.O. Box 198966, Nashville, TN 37219		

**SPECIAL WARRANTY DEED**

FOR AND IN CONSIDERATION of the sum of Ten and No/100 DOLLARS (\$10.00) cash in hand paid, and other good and valuable consideration, the receipt and sufficiency of all of which are hereby acknowledged, GOODLARK REGIONAL MEDICAL CENTER, INC., a Tennessee not-for-profit corporation and successor by merger to Goodlark Medical Center, Inc. (the "Grantor") has bargained and sold, and by these presents transfers and conveys to CENTRAL TENNESSEE HOSPITAL CORPORATION, a Tennessee corporation (the "Grantee"), Grantee's successors and assigns, certain land in Dickson and Cheatham Counties, State of Tennessee, being more particularly described in Exhibit A, which is attached hereto and incorporated herein by reference, together with all easements, rights-of-way, licenses, interests, rights and appurtenances thereto, any and all buildings, structures, open parking areas, and fixtures attached to said land (collectively the "Property").

This conveyance of the Property, and all covenants and warranties contained herein, are made expressly subject to the matters set forth on Exhibit B, which is attached hereto and incorporated herein by reference.

TO HAVE AND TO HOLD the Property, with all appurtenances, estate, title, and interest thereto belonging to the Grantee, Grantee's successors and assigns, forever.

Grantor covenants with the Grantee that Grantor is lawfully seized and possessed of good and indefeasible fee simple title to the Property; and that Grantor has a good and lawful right to sell and convey the same.

STATE OF TENNESSEE  
COUNTY OF DICKSON

The actual consideration or value, whichever is greater, for this transfer is \$48,000,000.

*[Signature]*  
Affiant

Subscribed and sworn to before me this 7 day of July, 1995.

*[Signature]*  
Notary Public

My Commission Expires: 11-95

171

October 29, 2015

3:45 pm

Subject to the matters set forth on Exhibit B, Grantor further covenants and binds itself, its successors and assigns, to warrant and forever defend the title to the Property to the Grantee, Grantee's successors and assigns against the lawful claims of all persons claiming by, through, or under Grantor, but not otherwise.

IN WITNESS WHEREOF, the Grantor has executed this Deed this 7 day of July, 1995.

GOODLARK REGIONAL MEDICAL  
CENTER, INC.

By: *[Signature]*Its: *[Signature]*

STATE OF TENNESSEE

COUNTY OF DICKSON

Before me, *[Signature]*, of the state and county mentioned, personally appeared *John N. Jackson*, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence) and who, upon oath, acknowledged himself to be the *President* of GOODLARK REGIONAL MEDICAL CENTER, INC., the within named bargainor, a corporation, and that he as such *President* executed the foregoing instrument for the purpose therein contained by signing the name of the corporation by himself as *President*

*[Signature]*  
Notary Public

My Commission Expires: *12-31-95*

STATE OF TENNESSEE, DICKSON COUNTY  
The foregoing instrument and certificate were noted in  
Note Book *Q*, Page *154* at *8:15* o'clock *A.M.* *7-11-1995*  
and recorded in Vol. *397*, Page *171* State Tax Paid *\$177.60*. 00  
Fee *1.00* Recording Fee *33.00* Total *\$177.60*  
Witness My Hand  
Receipt No. *6777*

*[Signature]*  
Registrar

**October 29, 2015****3:45 pm**

**EXHIBIT B**  
**Permitted Encumbrances**

1. General permit from Mrs. Doy Myatt Goodrum to Southern Bell Telephone and Telegraph Co. dated August 5, 1953, of record in Trust Book 72 at page 136 in the Register's Office of Dickson County, Tennessee. (Applies to Parcel 1)
2. An easement from J.T. Jackson to Town of Dickson dated September 9, 1966, of record in Deed Book 63 at page 10 in the Register's Office of Dickson County, Tennessee, for the purpose of constructing, maintaining, and repairing underground sewerage and/or water pipeline. (Applies to Parcel 1)
3. Utility easements as shown on the plat of Boundary Survey of the Goodlark Medical Center prepared by Ogden Environmental and Energy Services, 3325 Perimeter Hill Drive, Nashville, Tennessee 37211, Project No. 3-4057-0000-0000, dated April 9, 1993, and revised May 28, 1993. (Applies to Parcel 1)
4. Subject to the conditions set forth in the deeds of record in Volume 180 at page 275 and in Volume 180 at page 276, and in the deed of correction of record in Volume 366 at page 185, in the Register's Office of Dickson County, Tennessee. (Applies to Parcel 1)
5. Subject to the conditions set forth in the deed from the State of Tennessee to Goodlark Medical Center, Inc. dated October 11, 1985, of record in Volume 177 at page 313 in the Register's Office of Dickson County, Tennessee. (Applies to Parcel 1)
6. Taxes for the year 1995 and subsequent years.
7. All matters shown on the surveys prepared by Ogden Environmental and Energy Services, 3325 Perimeter Hill Drive, Nashville, Tennessee 37211, dated June 23, 1995 and June 28, 1995. (Applies to Parcels 1 & 2)
8. Utility easements set forth in the instrument of record in Book 82 at page 316 in the Register's Office of Cheatham County, Tennessee. (Applies to Parcel 2, Tract 1)

**October 29, 2015**

**3:45 pm**

**171**

**EXHIBIT B**  
**Permitted Encumbrances**  
**(Continued)**

9. Subject to the reservation of ingress and egress by Ashland City Bank & Trust Company, Inc. in the instrument of record in Book 236 at page 480 in the Register's Office of Cheatham County, Tennessee. (Applies to Parcel 2, Tract 1)
10. Rights of tenants in possession pursuant to unrecorded leases.

**October 29, 2015****3:45 pm**EXHIBIT A

**Parcel 1: Lying and being in the Fifth Civil District of Dickson County, State of Tennessee, and being more particularly described as follows:**

Beginning at an iron pin lying on the westerly right-of-way margin of U. S. Highway 70 and being the southerly corner of The Dickson Company property, of record in Volume 224 at page 280 in the Register's Office of Dickson County, Tennessee; thence with said westerly right-of-way margin of U. S. Highway 70, South 65 degrees 03 minutes 37 seconds West 1040.97 feet to an iron pin at the northeast corner of the First Union National Bank of Tennessee property, of record in Volume 119 at page 25, Volume 75 at page 166, and Deed Book 95 at page 300, R.O.D.C., Tennessee; thence with said First Union National Bank of Tennessee property, the following calls: North 16 degrees 50 minutes 57 seconds West 156.35 feet to an iron pin; South 78 degrees 49 minutes 34 seconds West 62.43 feet to an iron pin; North 57 degrees 15 minutes 31 seconds West 171.38 feet to an iron pin; North 02 degrees 07 minutes 29 seconds East 136.05 feet to an iron pin; North 19 degrees 02 minutes 07 seconds West 116.55 feet to an iron pin; North 67 degrees 08 minutes 09 seconds West 88.11 feet to an iron pin lying on the easterly right-of-way margin of State Highway 46; thence with said easterly right-of-way margin of State Highway 46, the following calls: North 19 degrees 42 minutes 04 seconds East 107.99 feet to an iron pin; North 36 degrees 06 minutes 15 seconds East 585.00 feet to a concrete monument; North 28 degrees 04 minutes 40 seconds East, crossing an iron pin at 38.18 feet and continuing 196.49 feet, in all, 234.67 feet to an iron pin at the southwesterly corner of the Charles H. Smart, Jr. and Larry Redden property, of record in Volume 121 at page 297, R.O.D.C., Tennessee; thence with said Smart and Redden property and also with the South Central Bell Telephone Company property, of record in Volume 6 at page 364, R.O.D.C., Tennessee, South 85 degrees 25 minutes 39 seconds East 792.72 feet to an iron pin at the southeast corner of the said South Central Bell Telephone property; thence with the westerly lines of The Dickson Company property, of record in Volume 224 at page 280, R.O.D.C., Tennessee, The Dickson Company property, of record in Volume 224 at page 280, R.O.D.C., Tennessee, the Phil Hall and J. C. Brown, Jr. property, of record in Volume 338 at page 97, R.O.D.C., Tennessee, The Dickson Company property, of record in Volume 224 at page 280, R.O.D.C., Tennessee, the LHS Family Limited Partnership property, of record in Volume 360 at page 56, R.O.D.C., Tennessee, The Dickson Company property, of record in Volume 224 at page 277, R.O.D.C., Tennessee, The Dickson Company property, of record in Volume 224 at page 280, R.O.D.C., Tennessee, the F.M. Cancer *et ux.* property, of record in Volume 228 at page 225, R.O.D.C., Tennessee, and The Dickson Company property, of record in Volume 224 at page 280, R.O.D.C., Tennessee, South 01 degree 57 minutes 30 seconds East 790.30 feet to the point of beginning, containing 26.682 acres, more or less, by survey of Ogden Environmental and Energy Services, 3325 Perimeter Hill Drive, Nashville, Tennessee 37211, dated 6/23/95, Proj.: 5-4159-0000-0000.

Being the same property conveyed to Goodlark General Hospital, Incorporated by deed from

**October 29, 2015****3:45 pm****171**

Lawrence Richard Jackson dated November 10, 1965, of record in Deed Book 98 at page 394 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Hospital Foundation, Inc. by deed from Goodlark General Hospital, Inc. dated December 31, 1966, of record in Deed Book 102 at page 61 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Hospital Foundation, Inc. by deed from Goodlark General Hospital, Inc. dated December 31, 1966, of record in Deed Book 102 at page 121 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Hospital Foundation, Incorporated by deed from L. C. Jackson and wife, Margaret Ison Jackson, James T. Jackson, and William M. Jackson dated May 4, 1973, of record in Volume 27 at page 260 in the Register's Office of Dickson County, Tennessee. Also being the same property in which J. T. Jackson and wife, Mary Ann Jackson, conveyed their one-third interest to Goodlark Hospital Foundation, Incorporated by deed dated December 16, 1974, of record in Volume 39 at page 80, and by deed of correction dated December 24, 1974, of record in Volume 39 at page 102, in the Register's Office of Dickson County, Tennessee. Also being the same property in which W. M. Jackson and wife, Margaret Jackson, conveyed their one-third interest to Goodlark Hospital Foundation, Incorporated by deed dated December 21, 1974, of record in Volume 39 at page 86, and by deed of correction dated December 24, 1974, of record in Volume 39 at page 103, in the Register's Office of Dickson County, Tennessee. Also being the same property in which L. C. Jackson and wife, Margaret Jackson, conveyed their one-third interest to Goodlark Hospital Foundation, Incorporated by deed dated December 30, 1974, of record in Volume 39 at page 130, and by deed of correction dated December 30, 1974, of record in Volume 39 at page 349, in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Hospital Foundation Inc. by deed from Dickson Land Company Incorporated dated August 22, 1979, of record in Volume 101 at page 186 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from James T. Jackson and wife, Mary Ann Jackson, L. C. Jackson and wife, Margaret I. Jackson, and Margaret P. Jackson dated January 4, 1985, of record in Volume 165 at page 143 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from James T. Jackson and wife, Mary Ann Jackson, dated January 4, 1985, of record in Volume 165 at page 145 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from Springfield Production Credit Association dated August 22, 1985, of record in Volume 174 at page 355 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from the State of Tennessee dated October 11, 1985, of record in Volume 177 at page 313 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Incorporated by deed from J. T. Jackson and wife, Mary Ann Jackson, L. C. Jackson and wife, Margaret I. Jackson, and Margaret P. Jackson dated December 31, 1985, of record in Volume 180 at page 276 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Incorporated by deed from J. T. Jackson and wife, Mary Ann Jackson, L. C. Jackson and wife, Margaret I. Jackson, and Margaret P. Jackson dated December 31, 1985, of record in Volume 180 at page 277 in the Register's Office of Dickson County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Incorporated by deed from First National Bank of Dickson dated December 5, 1985, of record in Volume 180 at page 278

**October 29, 2015****3:45 pm**

in the Register's Office of Dickson County, Tennessee. Also being the same property title to which was vested in Goodlark Regional Medical Center, Inc. by an amendment to the charter of Goodlark Medical Center, Inc. dated May 21, 1993, a certified copy of which is of record in Volume 352 at page 279 in the Register's Office of Dickson County, Tennessee.

**Parcel 2:** Lying and being in the Fifth Civil District of Cheatham County, State of Tennessee, and being more particularly described as follows:

**Tract 1:** Beginning at an iron rod lying 25 feet from the center of State Highway 12, the same being the southeast corner of Cumberland Electric Membership Corporation, of record in Deed Book 144 at page 21 in the Register's Office of Cheatham County, Tennessee; thence with said Cumberland Electric Membership Corporation's east line, North 59 degrees 37 minutes 50 seconds East 340.51 feet to an iron rod; thence South 31 degrees 36 minutes 10 seconds East, crossing an iron rod at 119.58 feet and continuing 155.58 feet in all, to a PK nail, the same being the northwest corner of the Seventh Day Adventist Church property, of record in Deed Book 82 at page 413, R.O.C.C., Tennessee; thence with said Seventh Day Adventist Church's west line, South 59 degrees 30 minutes 25 seconds West 135.27 feet to an iron rod, same being the southwest corner of the Seventh Day Adventist Church property; thence with the said Seventh Day Adventist Church's south line, South 27 degrees 28 minutes 21 seconds East, crossing an iron rod at 15.0 feet and continuing 45.00 feet in all, to an iron rod, same being the northwest corner of the Ashland City Bank and Trust Company property, of record in Deed Book 117 at page 40, R.O.C.C., Tennessee; thence with Ashland City Bank and Trust Company's west line, South 59 degrees 34 minutes 46 seconds West 202.35 feet to a PK nail lying in the north right-of-way margin of State Highway 12; thence with the North right-of-way margin of State Highway 12, North 31 degrees 30 minutes 00 seconds West 201.00 feet to the beginning, containing 1.429 acres, more or less, by survey of Ogden Environmental and Energy Services, 3325 Perimeter Hill Drive, Nashville, Tennessee 37211, dated 06/28/95, Proj: 5-4159-0000-0000.

Being the same property conveyed to Goodlark Medical Center, Inc. by deed from Janice Baldwin and husband, James M. Baldwin, dated July 19, 1985, of record in Deed Book 236 at page 477 in the Register's Office of Cheatham County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by quitclaim deed from the Town of Ashland City, Tennessee, dated July 22, 1985, of record in Deed Book 236 at page 483 in the Register's Office of Cheatham County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by quitclaim deed from Kentucky-Tennessee Conference Association of Seventh Day Adventist, Inc. dated February 25, 1986, of record in Deed Book 241 at page 541 in the Register's Office of Cheatham County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from Ashland City Bank and Trust Company, Inc. dated July 19, 1985, of record in Deed Book 236 at page 480 in the Register's Office of Cheatham County, Tennessee. Also being the same property conveyed to Goodlark Medical Center, Inc. by deed from Homer Tidwell, President, Ashland City Bank & Trust, dated September 30, 1986, of record in Deed Book 248 at page 438 in the Register's Office of Cheatham County, Tennessee. Also being the same property conveyed to Goodlark Regional Medical Center, Inc. by quitclaim deed from First Union National Bank of Tennessee dated May 17, 1995, of record in Deed

Book 372 at page 71 in the Register's Office of Cheatham County, Tennessee. Also being the same property title to which was vested in Goodlark Regional Medical Center, Inc. by an amendment to the charter of Goodlark Medical Center, Inc. dated May 21, 1993, a certified copy of which is of record in Deed Book Chart at page 424 in the Register's Office of Cheatham County, Tennessee.

Tract 2: Beginning at an iron rod located on the south right-of-way margin of State Highway 12, said point also being the northwest corner of the Joe M. Empson property, of record in Deed Book 238 at page 86 in the Register's Office of Cheatham County, Tennessee; thence with Joe M. Empson's west line, South 61 degrees 00 minutes 04 seconds West 229.78 feet to a concrete monument lying on the northerly line of the Earl H. Bradley property, of record in Deed Book 181 at page 554, R.O.C.C., Tennessee; thence with said Earl M. Bradley's northerly line, North 30 degrees 19 minutes 36 seconds West 109.27 feet to a concrete monument, said point also being the southeast corner of the Cheatham County Farm Bureau property, of record in Deed Book 177 at page 188, R.O.C.C., Tennessee; thence with said Cheatham County Farm Bureau's east line, North 60 degrees 51 minutes 20 seconds East 227.52 feet to an iron rod lying on the south right-of-way margin of State Highway 12; thence with the south right-of-way margin of State Highway 12, South 31 degrees 30 minutes 00 seconds East 109.92 feet to the point of beginning, containing 0.575 acres, more or less, by survey of Ogden Environmental and Energy Services, 3325 Perimeter Hill Drive, Nashville, Tennessee 37211, dated 06/28/95, Proj: 5-4159-0000-0000.

Being the same property conveyed to Goodlark Medical Center, Inc. by deed from Joe M. Empson dated November 21, 1989, of record in Deed Book 287 at page 177 in the Register's Office of Cheatham County, Tennessee. Also being the same property title to which was vested in Goodlark Regional Medical Center, Inc. by an amendment to the charter of Goodlark Medical Center, Inc. dated May 21, 1993, a certified copy of which is of record in Deed Book Chart at page 424 in the Register's Office of Cheatham County, Tennessee.

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

8967808  
License No.  
MD0000019241

State of Tennessee

Division Of Health Related Boards

Renewal No.  
786149

This Certifies that

MUHAMMAD S ISMAIL, MD

whose credentials have been approved by the

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized: MEDICAL DOCTOR

in the State of Tennessee through MARCH 31, 2016



*Boemerie O'H*

DIRECTOR, HEALTH RELATED BOARDS

14042

DCF014

**SUPPLEMENTAL #1**

October 29, 2015

3:45 pm

Renewal No.  
797722

State of Tennessee

SUPPLEMENTAL 8468028

October 29, 2015 No.  
3:45 pm MD0000017455

Division Of Health Related Boards

This Certifies that  
SUSAN B CAMPBELL, MD  
whose credentials have been approved by the:  
BOARD OF MEDICAL EXAMINERS  
has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized: MEDICAL DOCTOR  
in the State of Tennessee through MARCH 31, 2017



*Boemerie OHO*  
DIRECTOR, HEALTH-RELATED BOARDS

SUPPLEMENTAL

Renewal No.  
804143

State of Tennessee  
Division Of Health Related Boards

October 29, 2015  
3:45 pm License No.  
MD0000036669

*This Certifies that*  
**ASHRAF HOSNI M HAMDAN, MD**  
*whose credentials have been approved by the:*  
**BOARD OF MEDICAL EXAMINERS**  
*has fulfilled all requirements for renewal and registration as*  
*required by the Tennessee Code Annotated and is a duly*  
*authorized: MEDICAL DOCTOR*  
*in the State of Tennessee through* **AUGUST 31, 2017**



*Gaemarie Otto*  
DIRECTOR, HEALTH RELATED BOARDS

9186813

State of Tennessee

License No.

MD0000022081

Division Of Health Related Boards

Renewal No.

791134

This Certifies that

SARAH E HASSELL, MD

whose credentials have been approved by the

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized MEDICAL DOCTOR

in the State of Tennessee through AUGUST 31, 2016



*Sarah E. Hassell*

DIRECTOR, HEALTH RELATED BOARDS

14204

DCF014

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

Renewal No.  
786135

State of Tennessee

Division Of Health Related Boards

8967911  
License No.  
MD0000021215

This Certifies that

HADEER N KARMO, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized: MEDICAL DOCTOR

in the State of Tennessee through FEBRUARY 29, 2016



*Openerie OHO*  
DIRECTOR, HEALTH RELATED BOARDS

14042

DF014

**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

**October 29, 2015**

**3:45 pm**

9210788  
License No  
MD0000044049

State of Tennessee

Division Of Health Related Boards

Renewal No  
791891

This Certifies that

LARA ANN MCKEE, M.D.

whose credentials have been approved by the

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized MEDICAL DOCTOR

in the State of Tennessee through SEPTEMBER 30, 2016



*R. Penner*  
DIRECTOR, HEALTH RELATED BOARDS

14217

DCF014

Renewal No.  
794108

State of Tennessee

Division Of Health Related Boards

9303299

License No.  
MB00000626999

This Certifies that

ERIC SCOTT PALMER, MD

whose credentials have been approved by the:

BOARD OF MEDICAL EXAMINERS

has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized MEDICAL DOCTOR  
in the State of Tennessee through NOVEMBER 30, 2016



*Eric Scott Palmer*  
DIRECTOR, HEALTH RELATED BOARDS

DCF014 14283

**SUPPLEMENTAL #1**

October 29, 2015

3:45 pm

October 29, 2018 88.48

3:45 pm

Renewal No.  
798269

License No.  
MD0000025371

State of Tennessee  
Division Of Health Related Boards

*This Certifies that*

**DONNA-JEAN B. WALKER, MD**

*whose credentials have been approved by the:*

**BOARD OF MEDICAL EXAMINERS**

*has fulfilled all requirements for renewal and registration as  
required by the Tennessee Code Annotated and is a duly  
authorized: MEDICAL DOCTOR*

*in the State of Tennessee through* **MARCH 31, 2017**



*[Signature]*  
DIRECTOR, HEALTH-RELATED BOARDS

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# Search Results

**October 29, 2015****3:45 pm**

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1. CAMPBELL , SUSAN B  
Nashville, TN 37203

**License Number:** 17455**Status:** Licensed

View:

[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** Medical Doctor**Specialties:**[Neonatal-Perina](#)**Original Date:** 09/02/1986**Expiration Date:** 03/31/2017[Certification Letter](#)[Supervisory](#)[Relationships](#)

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October 29, 2015

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1. HAMDAN , ASHRAF HOSNI M  
Nashville, TN 37203

License Number: 36669

Status: Licensed

View:

[Practitioner Profile](#)

Profession: Medical Doctor

Rank: [Medical Doctor](#)

Specialties:

[Pediatrics](#)

Original Date: 08/21/2002

Expiration Date: 08/31/2017

[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**October 29, 2015****3:45 pm**

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1. HASSELL, SARAH E  
Nashville, TN 37203

**License Number:** 22081**Status:** Licensed

View:

[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** [Medical Doctor](#)**Specialties:**[Neonatal-Perina](#)**Original Date:** 01/07/1992**Expiration Date:** 08/31/2016[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**October 29, 2015****3:45 pm**

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1. ISMAIL , MUHAMMAD S  
Nashville, TN 37203

**License Number:** 19241**Status:** Licensed

View:

Practitioner Profile**Profession:** Medical Doctor**Rank:** Medical Doctor**Specialties:**Pediatrics**Original Date:** 10/04/1988**Expiration Date:** 03/31/2016Certification LetterSupervisoryRelationships

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

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1. KARMO , HADEER N  
Nashville, TN 37205

**License Number:** 21215**Status:** Licensed

View:

[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** Medical Doctor**Specialties:**Pediatrics**Original Date:** 12/13/1990**Expiration Date:** 02/29/2016[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

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1. MCKEE , LARA ANN  
Nashville, TN 37203

**License Number:** 44049**Status:** Licensed**View:**[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** Medical Doctor**Specialties:**Neonatal-Perina**Original Date:** 06/27/2008**Expiration Date:** 09/30/2016[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**SUPPLEMENTAL #1**

October 29, 2015

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1. PALMER, ERIC SCOTT  
Nashville, TN 37203

License Number: 26999

Status: Licensed

View:

[Practitioner Profile](#)

Profession: Medical Doctor

Rank: [Medical Doctor](#)

Specialties:

[Pediatrics](#)

Original Date: 06/07/1995

Expiration Date: 11/30/2016

[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**SUPPLEMENTAL #1**

October 29, 2015

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1. RAVENSCROFT, JENNY LEE  
Nashville, TN 37206

License Number: 44022

Status: Licensed

View:

[Practitioner Profile](#)

Profession: Medical Doctor

Rank: Medical Doctor

Specialties:

Neonatal-Perina

Original Date: 08/27/2008

Expiration Date: 07/31/2016

[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

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1. WALKER, DONNA-JEAN B.  
Jackson, TN 38305

**License Number:** 25371**Status:** Licensed

View:

[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** [Medical Doctor](#)**Specialties:**[Neonatal-Perina](#)**Original Date:** 02/16/1994**Expiration Date:** 03/31/2017[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**PEDIATRICIAN**

1. OJEDA, NESTOR A  
Waverly, TN 37185-2116

**License Number:** 21076**Status:** Licensed

View:

[Practitioner Profile](#)**Profession:** Medical Doctor**Rank:** Medical Doctor**Specialties:**

Pediatrics

**Original Date:** 09/18/1990**Expiration Date:** 10/31/2016[Certification Letter](#)

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**SUPPLEMENTAL #1**

**October 29, 2015**

**3:45 pm**

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**Search Results****October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. ADAMS , MARY LOU  
Jackson, TN 38305

**Profession:** Advanced Practice Nurse  
**Rank:** Advanced Practice Nurse  
**Qualifications:**  
NP with CF

**License Number:** 5821**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 07/31/2017

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# Search Results

**October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. BALDRIDGE , TRACY C  
Franklin, TN 37064

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 12246**Status:** Licensed

Valid in TN Only

**Original Date:** 09/07/2006**Expiration Date:** 02/28/2017

View:

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Licensure Verification

# Search Results

October 29, 2015

3:45 pm

You are viewing page 1 of 1...

1. BEAUMONT, LANE DOUGLASS  
Monteagle, TN 37356

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 13773**Status:** Licensed

Valid in TN Only

**Original Date:** 11/05/2008**Expiration Date:** 06/30/2017

View:

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**Search Results****October 29, 2015****3:45 pm**

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**1. BLATNIK , ANITA M**

Maryville, TN 37803

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 6871**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 02/29/2016

View:

[Practitioner Profile](#)[Certification Letter](#)**2. BLATNIK , VALERIE L**

Nashville, TN 37211

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 5734**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 01/31/2016

View:

[Practitioner Profile](#)[Certification Letter](#)[Supervisory](#)[Relationships](#)

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Licensure Verification

# Search Results

**October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. BROGDON, ELIZABETH M  
Nashville, TN 37221

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 11890**Status:** Licensed

Valid in TN Only

**Original Date:** 01/19/2006**Expiration Date:** 01/31/2017

View:

[Practitioner Profile](#)[Certification Letter](#)[Supervisory](#)[Relationships](#)

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**October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. BROWN, MARY HELEN  
Nashville, TN 37205

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 13765**Status:** Licensed

Valid in TN Only

**Original Date:** 11/04/2008**Expiration Date:** 05/31/2017

View:

[Practitioner Profile](#)[Certification Letter](#)[Supervisory](#)[Relationships](#)

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# Search Results

**October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. BYLSMA , SARAH J  
Gallatin, TN 37066

**Profession:** Advanced Practice Nurse  
**Rank:** Advanced Practice Nurse  
**Qualifications:**  
NP with CF

**License Number:** 16215**Status:** Licensed

Valid in TN Only

**Original Date:** 11/03/2011**Expiration Date:** 08/31/2016

View:

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

You are viewing page 1 of 1...

1. CASHION, LISA ANNE  
Huron, TN 38345

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 10951**Status:** Licensed

Valid in TN Only

**Original Date:** 05/13/2005**Expiration Date:** 03/31/2017

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**October 29, 2015****3:45 pm**

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1. DYCUS , BROOKE A. PERRY  
Nashville, TN 37203

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 12853**Status:** Licensed

Valid in TN Only

**Original Date:** 08/20/2007**Expiration Date:** 10/31/2016

View:

[Practitioner Profile](#)[Certification Letter](#)[Supervisory](#)[Relationships](#)

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1. EKLUND, WAKAKO M  
Nashville, TN 37209

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 6866**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 07/31/2016

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1. HAMMOND, KRISTI G  
Georgetown, KY 40324

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 14989**Status:** Licensed

Valid in TN Only

**Original Date:** 05/27/2010**Expiration Date:** 12/31/2016

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1. HARRISON , KATHERINE RYND  
Nashville, TN 37203

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 6611**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 04/30/2017

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1. HERMAN, VICKI L  
Clarksville, TN 37043

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP

**License Number:** 12782**Status:** Licensed

Valid in TN Only

**Original Date:** 07/13/2007**Expiration Date:** 08/31/2017

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1. HOFFERT, KORI R  
Shelbyville, TN 37160

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 16524**Status:** Licensed

Valid in TN Only

**Original Date:** 02/22/2012**Expiration Date:** 05/31/2017

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

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1. HUFF, CHRISTY  
Brentwood, TN 37027

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 13674**Status:** Licensed

Valid in TN Only

**Original Date:** 09/22/2008**Expiration Date:** 08/31/2016

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**SUPPLEMENTAL #1****October 29, 2015****3:45 pm**

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1. HUGHES , ADRIENE L  
Mount Juliet, TN 37122

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 16126**Status:** Licensed

Valid in TN Only

**Original Date:** 10/28/2011**Expiration Date:** 01/31/2016

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1. JORDAN , KERI N  
Nashville, TN 37203

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 18660**Status:** Licensed

Valid in TN Only

**Original Date:** 05/29/2014**Expiration Date:** 12/31/2016

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1. OLDHAM , LINDSEY ANN  
Murfreesboro, TN 37128

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 17963**Status:** Licensed

Valid in TN Only

**Original Date:** 09/10/2013**Expiration Date:** 09/30/2017

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1. ROHLING , CARRIE ELIZABETH  
Nashville, TN 37209

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 16349**Status:** Licensed

Valid in TN Only

**Original Date:** 12/05/2011**Expiration Date:** 02/29/2016

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1. SCOTT, PATRICIA A  
Lebanon, TN 37090

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 5979**Status:** Licensed

Valid in TN Only

**Original Date:** 08/13/2004**Expiration Date:** 07/31/2017

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**October 29, 2015****3:45 pm**

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1. SAWYER , CHRISTIE M  
Nashville, TN 37221

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 11187**Status:** Licensed

Valid in TN Only

**Original Date:** 04/18/2005**Expiration Date:** 08/31/2016

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**October 29, 2015****3:45 pm**

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1. STEPHENS , KAREN M  
Nolensville, TN 37135

**Profession:** Advanced Practice Nurse**Rank:** Advanced Practice Nurse**Qualifications:**

NP with CF

**License Number:** 17889**Status:** Licensed

Valid in TN Only

**Original Date:** 09/04/2013**Expiration Date:** 11/30/2016

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**October 29, 2015**

**3:45 pm**

**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

TRISTAR HORIZON NICK

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

John Wellborn  
Signature/Title  
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 29<sup>th</sup> day of October, 2015,  
witness my hand at office in the County of DAVIDSON, State of Tennessee.

[Signature]  
NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

